91-1534

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In The Supreme Court of the United States October Term, 1991

TOTAL CARE, INC.,

Petitioner,

v.

LOUIS SULLIVAN, Secretary of the United States Department of Health and Human Services; GAIL WILENSKY, Administrator of the Health Care Financing Administration; GEORGE R. HOLLAND, Regional Administrator of Region IV of the Health Care Financing Administration; JAMES C. HOLLOWAY, Executive Director, Department of Operations for Federal Programs of BLUE CROSS AND BLUE SHIELD ASSOCIATION; and BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

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QUESTIONS PRESENTED

In a Medicare case brought by a provider of services without prior exhaustion of administrative remedies where the sole Medicare administrative hearing body available to providers, the Provider Reimbursement Review Board, and any subsequent reviewing court lack authority to hear the provider's claim that the Secretary of the United States Department of Health and Human Services and his subcontractors have ignored the applicable reimbursement regulation and implementing instructions for over sixteen years-

1. Does 42 U.S.C. §405(h) preclude Mandamus jurisdiction?
2. Does 42 U.S.C. §405(h) preclude Federal Question jurisdiction?

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED i

TABLE OF CONTENTS ii

TABLE OF AUTHORITIES iv

REFERENCE TO OFFICIAL AND UNOFFICIAL REPORTS OF OPINIONS BELOW viii

STATEMENT OF JURISDICTION viii

TEXT OF STATUTES, REGULATIONS AND MEDICARE GENERAL INSTRUCTIONS viii

STATEMENT OF THE CASE

I. Introduction to the Parties 1

II. Overview of the Medicare Program: Principles of Provider Reimbursement and Appeals 3

III. The Owners Compensation Issue 4

IV. The Facts Underlying This Controversy 6

V. The Nature of Total Care's Claim in This Court 10

ARGUMENTS FOR ALLOWANCE OF WRIT

I. By Precluding Judicial Review Over Medicare Claims For Which There Is No Administrative Remedy, The United States Court Of Appeals For The Fourth Circuit Has Decided An Important Question Of Federal Constitutional Law Which Has Not Been, But Which Should Be, Settled By This Supreme Court 14

II. The Decision Of The Fourth Circuit That 42 U.S.C. §405(h) Is A Bar To Mandamus Where There Is No Other Forum For Relief Through The Administrative Process Conflicts With The Decisions Of The Court Of Appeals For The District Of Columbia Circuit And Several Lower Courts 16

Page

III. The Decision Of The Fourth Circuit That 42 U.S.C. §405(h) Is A Bar To Federal Question Jurisdiction Where There Is No Other Forum For Relief Through The Administrative Process Conflicts With The Decisions Of The Courts Of Appeal For The First, Second, Sixth, Eighth, And District Of Columbia Circuits 20

CONCLUSION 24

APPENDIX

A. Unpublished Decision of the United States Court of Appeals for the Fourth Circuit (December 23, 1991) 1a

B. Order of United States District Judge James B. McMillan (September 6, 1990) 7a

C. Memorandum of Decision and Order and Judgment of Chief United States District Judge Robert D. Potter (January 7, 1991) 8a

D. Order of United States District Judge Robert D. Potter (March 6, 1991) 22a

E. Select Provisions of the Medicare Provider Reimbursement Manual (HIM 15), Chapter 9 ..... 24a

TABLE OF AUTHORITIES

Cases: *Page*

Abbott Laboratories v. Gardner, 387 U.S. 136 (1967) 22

American Ambulance Service of Pa., Inc. v. Sullivan, 911 F.2d 901 (3d Cir. 1991) 20

Anderjar v. Weinberger, 69 F.R.D. 690 (S.D.N.Y. 1976) 18

Belles v. Schweiker, 720 F.2d 509 (8th Cir. 1983) 19

Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667 (1986) 20-21

Cablevision Systems Development Co. v. Motion Picture Association of America, Inc., 836 F.2d 599 (D.C. Cir. 1988), *cert. denied*, 487 U.S. 1235 (1988) 16

Califano v. Yamasaki, 442 U.S. 682 (1979) 16, 19

Caswell v. Califano, 435 F. Supp. 127 (D. Me. 1977), aff'd, 583 F.2d 9 (1st Cir. 1978) 19

Chelsea Community Hospital v. Michigan Blue Cross Association, 630 F.2d 1131 (6th Cir. 1980) 23

Columbia Broadcasting System v. U.S., 316 U.S. 407 (1942) ... 14

Community Action of Laramie County, Inc. v. Bowen, 866 F.2d 347 (10th Cir. 1989) 24

Elliot v. Weinberger, 564 F.2d 1219 (9th Cir. 1977), *aff'd in part, rev'd in part on other grounds sub. nom., Califano v. Yamasaki*, 442 U.S. 682 (1979) 18

Ellis v. Blum, 643 F.2d 68 (2d Cir. 1981) 19

Ganem v. Heckler, 746 F.2d 844 (D.C. Cir. 1984) 19

Heckler v. Ringer, 466 U.S. 602 (1984) 16-17, 18, 19

Hospital San Jorge, Inc. v. U.S., 598 F.2d 684 (lst Cir. 1979).... 22

International House v. N.L.R.B., 676 F.2d 906 (2d Cir. 1982) ... 15

Johnson v. Robinson, 415 U.S. 361 (1974) 22, 23

Page

Karnak Educational Trust v. Bowen, 821 F.2d 1517 (11th Cir. 1987) 20

Lopez v. Heckler, 725 F.2d 1489 (9th Cir. 1984) 19

Martinez v. Richardson, 472 F.2d 1121 (10th Cir. 1983) 19

Massachusetts Fair Share v. Law Enforcement Assistance Administration, 758 F.2d 708 (D.C. Cir. 1985) 15

Mathews v. Eldridge, 424 U.S. 319 (1976) 16, 18, 19

Matos v. Secretary of HEW, 581 F.2d 282 (1st Cir. 1978) 19

McMahon v. Califano, 476 F. Supp. 978 (D. Mass. 1979) 18-19

Monger v. Bowen, 817 F.2d 15 (4th Cir. 1987) 17-18

Monongahela Valley Hospital, Inc. v. Bowen, 728 F. Supp. 1172 (W.D. Pa. 1990) 11

Montilla v. Immigration and Naturalization Service 926 F.2d 162 (2d Cir. 1991) 15

Morton v. Ruiz, 415 U.S. 199 (1974) 15

National Association of Home Health Agencies v. Schweiker, 690 F.2d 932 (D.C. Cir. 1982), *cert. denied*, 459 U.S. 1205 (1983) 24

Norton v. Mathews, 427 U.S. 524 (1979) 16, 19

Pacific Molasses Co. v. F.T.C., 356 F.2d 386 (5th Cir. 1966) 14

Rusk v. Cort, 369 U.S. 367 (1962) 22

Service v. Dulles, 354 U.S. 363 (1957) 14

St. Louis University v. Blue Cross Hospital Service, 537 F.2d 283 (8th Cir.), *cert. denied*, 429 U.S. 977 (1976) 23, 24

Smith v. Resor, 406 F.2d 141 (2d Cir. 1990) 14

South Windsor Convalescent Home, Inc. v. Mathews, 541 F.2d 910 (2d Cir. 1976) 17, 22

Page

Starnes v. Schweiker, 715 F.2d 134 (4th Cir. 1983), *vacated on other grounds sub. nom. Starnes v. Heckler*, 467 U.S. 1223 (1984), *cert. denied.*, 471 U.S. 1017 (1985) 19

Thomas Brooks Chartered v. Burnett, 920 F.2d 634 (10th Cir. 1990) 14, 24

Total Care, Inc. v. Sullivan, et. al., No. 91-1514 (4th Cir. 1991) 10

Total Care, Inc. v. Sullivan, et. al., 754 F. Supp. 1097 (W.D.N.C. 1991) 10

Trinity Memorial Hospital v. Associated Hospital Service, 570 F.2d 660 (7th Cir. 1977) 19

U.S. v. Aquavella, 615 F.2d 12 (2d Cir. 1979), *modified on reh'g* (2d Cir. 1980) 22

U.S. v. Heffner, 420 F.2d 809 (4th Cir. 1970) 15

U.S. v. Leahey, 434 F.2d 7 (1st Cir. 1970) 15

United States ex. rel. Accardi v. Shaughnessy, 347 U.S. 260 (1954) 14

Weinberger v. Salfi, 422 U.S. 749 (1974) 21, 22, 23

Whitecliff, Inc. v. U.S., 536 F.2d 347 (Ct. Cl. 1976), *cert. denied*, 430 U.S. 969 (1977) 23

Yellin v. U.S., 374 U.S. 109 (1983) 14

Statutes and Rules:

5 U.S.C. §706 ..... 4, 13
28 U.S.C. §1254(1) viii
28 U.S.C. §1291 10
28 U.S.C. §1294 10
28 U.S.C. §1331 ..... 10, 20-24
28 U.S.C. §1361 ..... 10, 16-20
42 U.S.C. §405(g) 17, 22
42 U.S.C. §405(h) 10-11, 13, 16-24

Page

42 U.S.C. §1395c 3
42 U.S.C. §1395f(b) 3
42 U.S.C. §1395h 2
42 U.S.C. §1395k 3
42 U.S.C. §1395u(b)(3)(C) 20
42 U.S.C. §1395x(m) 2
42 U.S.C. §1395x(u) 1
42 U.S.C. §1395x(v)(1)(A) 3,5
42 U.S.C. §1395ii 11, 13, 17
42 U.S.C. §1395oo 17
42 U.S.C. §1395oo(f) 8, 12
42 U.S.C. §1395oo(f)(1) 4
42 C.F.R. §405.1801(a) 4, 12
42 C.F.R. §405.1803(a) 4
42 C.F.R. §405.1835 ..... 4, 12
42 C.F.R. §405.1869 ..... 4. 12
42 C.F.R. §405.1875 4
42 C.F.R. §405.1877 4
42 C.F.R. §413.24(f) 4
42 C.F.R. §413.102 ..... 5, 6

Other:

Provider Reimbursement Manual (Part 1) §904 5
Provider Reimbursement Manual (Part 1) §905.1 6
Provider Reimbursement Manual (Part 1) §905.2 6
Medicare Intermediary Manual (HIM 13) (Part 2) §2120.1 6

Medicare and the American Health Care System,
Prospective Payment Commission Report to Congress,
June 1991 (CCH) 3

REFERENCE TO OFFICIAL AND UNOFFICIAL REPORTS OF OPINIONS BELOW

The opinion of the Court of Appeals for the Fourth Circuit in *Total Care, Inc. v. Sullivan, et. al.*, No. 91-1514 (4th Cir. 1991) is not reported but appears in the Appendix hereto. The order and memorandum of the District Court is reported at 754 F. Supp. 1097, and is reprinted in the Appendix hereto.

STATEMENT OF JURISDICTION

This petition for writ of certiorari to the United States Court of Appeals for the Fourth Circuit is based on 28 U.S.C. § 1254 (1). The date of entry of the judgment sought to be reviewed is December 23, 1991.

TEXT OF STATUTES, REGULATIONS, AND MEDICARE GENERAL INSTRUCTIONS

1. *42 U.S.C. §405(h) of the Medicare Act*
   (also referred to as Section 205(h) of Title II of the Social Security Act) -

   > The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary or any officer or employee thereof shall be brought under Section 1331 or 1346 of Title 28, United States Code, to recover on any claim arising under this title [II].

2. *42 U.S.C. §1395ii of the Medicare Act*
   The provisions of sections 206 and 216(j) and of subsections (a), (d), (e), (h), (i), (j), (k), and (l) of section 205, shall also apply with respect to this title [XVIII] to the same extent as they are applicable with respect to title II.

3. *42 C.F.R. §413.102*
   A reasonable allowance of compensation for services of owners is an allowable cost, provided the services

> are actually performed in a necessary function . . . Reasonableness of compensation may be determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable institutions; or it may be determined by other appropriate means.

4. Medicare Provider Reimbursement Manual (HIM 15), Chapter 9-Select provisions set forth in Appendix

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TOTAL CARE, INC.,

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v.

LOUIS SULLIVAN, Secretary of the United States Department of Health and Human Services; GAIL WILENSKY, Administrator of the Health Care Financing Administration; GEORGE R. HOLLAND, Regional Administrator of Region IV of the Health Care Financing Administration; JAMES C. HOLLOWAY, Executive Director, Department of Operations for Federal Programs of BLUE CROSS AND BLUE SHIELD ASSOCIATION; and BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

STATEMENT OF THE CASE

I. Introduction to the Parties

The Petitioner, Total Care, Inc. ("Total Care"), is a home health agency ("HHA") organized under the laws of North Carolina and licensed to provide home health services to patients in both North and South Carolina. Since 1978, Total Care has participated in the Medicare Program ("Medicare" or the "Program") as a "provider" of home health services. *See*, 42 U.S.C. §1395x(u). "Home health services" are defined under the Program

to include parttime or intermittent nursing care; physical, occupational, and speech therapy; medical social services; medical supplies; and the services of a trained home health aide. 42 U.S.C. §1395x(m).

Total Care employs approximately two hundred twenty one (221) persons, and almost seventy percent (70%) of its operating expenses are payroll related. Most of Total Care's patients are Medicare beneficiaries, and Total Care is greatly dependent upon timely reimbursement from the Medicare Program to cover its costs of providing home care.

Respondent Louis Sullivan is the Secretary ("Secretary") of the United States Department of Health and Human Services ("HHS"), the federal officer responsible for administering the Medicare Program. Respondent Gail Wilensky was the Administrator of the Health Care Financing Administration ("HCFA"), the agency within HHS responsible for managing Medicare payments to providers of services. Respondent George Holland is the Regional Administrator of the Atlanta Region of HCFA (also referred to as "Region IV" of HCFA), the administrative region in which Total Care is located.

Respondent Blue Cross and Blue Shield Association ("BC/BSA") is the Chief Fiscal Intermediary under contract with HCFA to review the annual cost reports of Medicare providers, to determine the amount of Program reimbursement due to or owing from such providers, and to coordinate giving advise to and interfacing with the providers. *See* 42 U.S.C. §1395h. BC/BSA performs its functions through subcontractors like Blue Cross and Blue Shield of North Carolina ("BC/BS-NC"), which is not a party to this lawsuit, and Respondent Blue Cross and Blue Shield of South Carolina ("BC/BS-SC"). The subcontracting intermediaries are also referred to as "local" intermediaries, and BC/BSA and its subcontractors are sometimes collectively referred to as "the Intermediary."

The Intermediary is bound by Medicare statute, implementing regulations, and general instructions. "General instructions" are interpretive rules issued by the Secretary to the Medicare subcontractors which are not promulgated as regulations under the formal notice and comment procedures of the Administrative

Procedures Act ("APA"). The general instructions have been arranged into a series of published "manuals" for intermediaries, providers, and other Medicare participants. As BC/BSA and the local intermediaries are all subcontracting agents of the Secretary, they have no independent policy making or lawmaking authority.

II. Overview of the Medicare Program: Principles of Provider Reimbursement and Appeals

Medicare was established in 1965 as Title XVIII of the Social Security Act to provide health insurance for the aged, blind and disabled. In 1990, the federal government spent $110 billion on Medicare services, approximately $3.7 billion of which went to home health benefits for about 34 million Medicare beneficiaries. *Medicare and the American Health Care System*, Prospective Payment Commission Report to Congress, June 1991, pp. 22, 98 (CCH).

The Medicare Program is divided into two (2) parts: Part A "Hospital Insurance Benefits" covers hospital, post-hospital, home health and hospice benefits, *see* 42 U.S.C. §1395c; payment for which is made by an "intermediary". Part B "Supplementary Medical Insurance Benefits" covers physicians' services, home health services, and other outpatient care services. 42 U.S.C. §1395k. Part B payments are generally administered by Medicare "carriers", although intermediaries also play a role in Part B payments.

As a "provider of services" under both Part A and Part B, Total Care is entitled to reimbursement for the "reasonable cost" of providing services to Medicare beneficiaries. 42 U.S.C. 1395f(b). Other "providers of services" include hospitals and skilled nursing facilities. "Reasonable cost" is defined as the cost actually incurred in the delivery of services, excluding any cost found to be unnecessary in the efficient delivery of needed health services, as determined in accordance with regulations issued by the Secretary. 42 U.S.C. §1395x(v)(l)(A).

In order to receive such reimbursement from the Program, a provider such as Total Care is required to file a cost report with its Intermediary at the end of each of its fiscal years ("FYs").

42 C.F.R. §413.24(f). Upon receipt of each such cost report, the Intermediary must perform an audit and furnish the provider with a written Notice of Program Reimbursement ("NPR") reflecting the "Intermediary's determination" of the total amount of reimbursement due. 42 C.F.R. §§405.1801(a) and 1803(a).

If a provider is dissatisfied with the Intermediary's determination, it may obtain review from the Provider Reimbursement Review Board ("PRRB" or the "Board") where the amount in controversy is $10,000.00 or more. 42 C.F.R. §405.1835. The PRRB is the administrative hearing body of HCFA located in Baltimore, Maryland. The PRRB has the power to affirm, modify, or reverse a determination of the Intermediary and to make any other modifications on matters "covered by" the cost report regardless of whether such matters are considered in the Intermediary's determination. 42 C.F.R. §405.1869. The Administrator of HCFA ("Administrator") has the discretion to review a decision of the Board. 42 C.F.R §405.1875.

Should a provider be dissatisfied with the "final" decision or the Board or HCFA Administrator, it is then entitled to judicial review. 42 C.F.R. §405.1877. The Medicare Act states that such a lawsuit shall be tried in federal district court in accordance with the applicable provisions of chapter 7 of title 5, United States Code-i.e., the Administrative Procedures Act. 42 U.S.C. 1395oo(f)(1).

The provisions of §706 of the APA, which govern the scope of review on appeal from the decision of an administrative agency, state that the court shall:

> hold unlawful and set aside agency action, findings, and conclusions found to be - . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law . . . or unsupported by substantial evidence . . .

5 U.S.C. §706.

III. The Owners Compensation Issue

The Medicare Act states that a provider of services is entitled to reimbursement for the "reasonable cost" of providing covered

health services to beneficiaries as determined in accordance with regulations to be issued by the Secretary. 42 U.S.C. 1395x(v)(l)(A). In accordance with this authority, the Secretary issued the following regulation in 1966:

> A reasonable allowance of compensation for services of owners is an allowable cost, provided the services are actually performed in a necessary function . . . *Reasonableness of compensation may be determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable institutions; or it may be determined by other appropriate means.*

42 C.F.R §413.102 (emphasis supplied).

In 1969, the Secretary issued general instructions on the subject of owners' compensation which state that:

> In general, the determination as to the reasonableness of a person's compensation is made by comparing it with the compensation paid to other individuals in similar circumstances. To obtain uniformity in the application of the principle, the Intermediary (1) identifies compensation paid to individuals other than owners by comparable institutions in the same geographical area, (2) furnishes this data to the. . [HCFA] regional office where it is consolidated with data obtained by other intermediaries to produce ranges of reasonable compensation to be used in the same area, and (3) applies a set of criteria based on the qualifications and responsibilities of the owner to determine his placement within the range.

Provider Reimbursement Manual (Part 1) ("PRM-1") §904 in *Medicare and Medicaid Guide* ("CCH") ¶5607.

The general instructions are quite detailed as to how the Intermediary should apply the ranges of compensation to make appropriate cost report adjustments. Moreover, the general instructions expressly state that:

> Intermediaries have the responsibility for evaluating the reasonableness of an owner's compensation . . . On the basis of information obtained by surveys of providers, ranges of compensation for comparable institutions will be established. Intermediaries will utilize these ranges both for final settlement and when setting interim rates.

PRM-1 §905.1 in CCH ¶5619.

The general instructions provide that, where it is possible to obtain the necessary nonowner salary data without conducting surveys, "the regional office will advise the intermediaries if surveys shall be deemed unnecessary." Medicare Intermediary Manual (HIM 13) (Part 2) §2120.1 in CCH ¶5607.09.

Despite the clear directives of the general instructions, no national surveys have been conducted and no ranges have been published by HCFA since 1974. *See* PRM-1 §905.2. The subcontracting intermediaries in HCFA Region IV have not conducted surveys or developed ranges since then; however, the Atlanta Regional Office of HCFA has not "advised" the intermediaries in that region that "surveys shall be deemed unnecessary." Moreover, HCFA has not promulgated any regulations or general instructions as to what constitutes "other appropriate means" to determine reasonable compensation as an alternative to the surveys under 42 C.F.R. §413.102.

The result is that subcontracting intermediaries in the various states have unilaterally adopted and applied their own methodologies for adjusting owners' compensation. Methodologies thus differ between the states. Some local intermediaries even use more than one methodology for similar providers in the same geographic area during the same fiscal year. In the present case, at least two different methodologies were used to adjust Total Care's claimed owners' compensation during one fiscal year.

IV. The Facts Underlying This Controversy

For fiscal years 1984 to 1986, Total Care filed its annual cost report with its local intermediary, Blue Cross and Blue Shield of North Carolina, claiming an amount for owner's compensation

in each year. BC/BSA eventually allowed the full amount claimed by Total Care in each of those years.

In 1987, Respondent Blue Cross and Blue Shield of South Carolina became Total Care's local intermediary. During the audit of Total Care's filed cost report for FY 1987, BC/BS-SC adjusted claimed owners' compensation by $30,000.00 to an amount less than the amount previously allowed by BC/BC-NC in 1984. BC/BS-SC cited as the basis for its adjustment a methodology purportedly entitled the "Tennessee Point System."

In response to this dramatic 1987 salary adjustment, the President of Total Care wrote to BC/BS-SC requesting background information about the Tennessee Point System and the underlying data used to develop it. Prior to this time, the President of Total Care had no knowledge of the Tennessee Point System as a methodology for adjusting owners' compensation in HCFA's Region IV.

In response to Total Care's inquiry, BC/BS-SC provided Total Care with copies of two (2) documents: a listing of HHA Compensation Ranges ("Compensation Ranges") and an Owners Compensation Questionnaire ("Questionnaire").

Based on these two documents and the Intermediary's limited response to discovery in the District Court and before the PRRB, the Petitioner has determined that the Tennessee Point System works as follows: The Compensation Ranges indicate a high and low value of "allowable" compensation for HHAs rendering 30,000 or more visits (a "large" agency) or less than 30,000 visits (a "small" agency) in each year between 1975 and 1988, using a HCFA inflation factor. Based on responses given by Total Care's chief executive officer ("CEO") to a series of questions about her education, prior experience, and hours worked, BC/BS-SC awarded Total Care's CEO 84 "points" out of 100 possible "points" on the Questionnaire. Taking the low value of the applicable Compensation Range for Total Care for 1987 as a base "allowable" salary, BC/BC-SC then derived a compensation "cap" for Total Care's CEO by adjusting the low value upward by 84% of the difference between the low value and the high value of the applicable Compensation Range. BC/BS-SC's audit adjustment report for Total Care's FY 1987 only

allows a salary for Total Care's CEO equal to the "cap" derived under this alleged Tennessee Point System methodology.

There is no evidence in the record, however, whether such a compensation "cap" reflects a reasonable amount of salary as required by Medicare regulations. Despite Total Care's attempts to uncover the data used to develop the Tennessee Point System through discovery in court and before the PRRB and under the Freedom of Information Act, the underlying data for the Compensation Ranges have never been disclosed to Total Care. At best, the Compensation Ranges appear to reflect some unaudited "salary" data gathered from unnamed providers of unspecified health care services operating in an undisclosed geographic area.

Total Care appealed BC/BS-SC's 1987 salary adjustment to the PRRB and requested a ruling on the Board's jurisdiction to hear the case, also referred to as a request for expedited judicial review ("EJR"). *See* 42 U.S.C. §1395oo(f). The PRRB ultimately rejected Total Care's request for EJR and held an administrative hearing on the case.

Much to Total Care's surprise, at the PRRB hearing conducted on January 3 and 4, 1991, the Intermediary completely abandoned its adjustment to Total Care's compensation based on the Tennessee Point System. During its opening statements made at the PRRB proceeding, the Intermediary informed the PRRB and Total Care that it was proposing an alternative, slightly higher adjustment to owners' salary for FY 1987 in accordance with its retroactive application of a methodology created in 1990 and referred to as "Dunham II."

The Dunham II methodology for analyzing the reasonableness of claimed executive compensation was developed by Dr. Randall Dunham, a compensation expert and Professor of Business at the University of Wisconsin in Madison, Wisconsin, who testified at the PRRB in support of the reasonableness of Total Care's claimed owners' salary for 1987. Dr. Dunham developed his Dunham II system in the summer of 1990 when he was commissioned to study the issue by BC/BS-SC and a coalition of home health agencies in North Carolina, South Carolina, Tennessee, and Kentucky ("4-State Coalition").

Through use of a Professional and Managerial Position Questionnaire ("PMPQ"), an econometric tool for assessing the overall responsibility level for a job expressed as a number of "points," Dr. Dunham was able to compare the responsibility levels of various HHA administrators' positions with similar positions in hospitals. Then, because a fairly well established market for hospital jobs has existed for some time, Dr. Dunham was able to derive a *salary range* for each HHA key executive by determining how much salary a comparable hospital position with the same number of PMPQ "points" could command. Dr. Dunham's findings were issued to BC/BS-SC and the 4-State Coalition on or about September 15, 1990.

Total Care participated in the 1990 Dunham II study and, based upon the 2830 "points" awarded to Total Care's CEO, Dr. Dunham determined a reasonable salary range for her position in 1990 (exclusive of fringe benefits) based on comparable hospital jobs. During the PRRB hearing, Dr. Dunham emphasized the importance of establishing a *range* of appropriate compensation to give each particular HHA discretion in rewarding its executives based on their individual performances.

At the PRRB hearing, however, the Intermediary argued that, for Medicare purposes, the salary for Total Care's CEO should be limited to the mathematical midpoint of the salary range derived under the 1990 Dunham II methodology, adjusted retroactively to 1987.

The Intermediary has not supplied any evidence in the record created in this lawsuit or before the PRRB that BC/BS-SC was authorized by BC/BSA, HCFA, or HHS to utilize either the Tennessee Point System or Dunham II as a mechanism for measuring the reasonableness of claimed owners' salaries. Moreover, neither of these two methodologies had ever been used previously in North or South Carolina, and no notice of their official use was given to Total Care prior to the Intermediary's opening statements made during the PRRB hearing.

On August 22, 1991, the PRRB reversed the Intermediary's adjustments and awarded Total Care the full amount of its claimed owners' compensation for FY 1987. Because there is no enforceable law as to the appropriate methodology for making

adjustments to owners' compensation, however, the PRRB's decision has no binding effect on future fiscal years. Further, as the Intermediary's actions during the PRRB hearing demonstrates, what methodology the Intermediary will utilize to adjust owners' salary in future years remains an open question.

V. The Nature of Total Care's Claim in This Court

Total Care filed its complaint in the United States District Court on April 25, 1990, under 28 U.S.C §§1331 and 1361. Rather than answer the complaint, Defendants (Respondents herein) filed a Motion to Dismiss for Lack of Jurisdiction. On September 6, 1990, the Honorable Judge James McMillan denied Defendants' motion and accepted jurisdiction over Total Care's complaint without prejudice to the Defendants.

The case was subsequently reassigned to Judge Robert Potter, however, after Judge McMillan assumed senior status on the United States District Court. Immediately following the reassignment of judges, the Defendants renewed their Motion to Dismiss for Lack of Jurisdiction. Ultimately, on January 8, 1991, Judge Potter granted the Defendants' Motion to Dismiss for Lack of Jurisdiction, *see Total Care, Inc. v. Sullivan, et. al.*, 754 F. Supp. 1097 (W.D.N.C. 1991), and later, on March 6, 1991, denied Total Care's request to Alter and/or Amend the Judgment so entered.

Total Care then appealed to the United States Court of Appeals for the Fourth Circuit under 28 U.S.C. §§1291 and 1294, arguing that Judge Potter's decision was erroneous and that the District Court should accept Mandamus and/or Federal Question jurisdiction over the case. The parties filed briefs on the jurisdictional issue, and oral argument was held on October 2, 1991. On December 23, 1991, the Fourth Circuit issued an unpublished opinion affirming the District Court's dismissal of the case for failure to exhaust administrative remedies. *Total Care, Inc. v. Sullivan, et. al.*, No. 91-1514 (4th Cir. 1991).

The District Court and the Fourth Circuit ruled that, because Total Care filed suit prior to the resolution of its appeal before the PRRB, it is barred from judicial review by virtue of 42 U.S.C. §405(h) which states, in pertinent part:

> No action against the United States, the Secretary or any officer or employee thereof shall be brought under Section 1331 or 1346 of Title 28, United States Code, to recover on any claim arising under this title [II of the Social Security Act].

This provision (§205(h)) of Title II of the Social Security Act is applicable to Medicare, Title XVIII of the Social Security Act, by virtue of 42 U.S.C. §1395ii, which states that:

> The provisions of sections 206 and 216(j) and of subsections (a), (d), (e), (h), (i), (j), (k), and (l) of section 205, shall also apply with respect to this title [XVIII] to the same extent as they are applicable with respect to title II.

Total Care's original complaint in the District Court challenged Respondents' failure to establish ranges or other appropriate means for assessing the reasonableness of owners' compensation through the appropriate regulatory process, and implicitly questioned the Secretary's delegation of rulemaking authority on this matter to the local intermediaries through inaction. The Medicare Act does not authorize such delegation. As one court stated:

> The Fiscal Intermediary is only a hired hand, an independent contractor selected by the government to conduct the audits. The Fiscal Intermediary cannot speak with finality for the Secretary on the interpretation of regulations and certainly cannot make policy pronouncements.

Monongahela Valley Hospital, Inc. v. Bowen, 728 F. Supp. 1172, 1175 (W.D. Pa. 1990).

Because Respondents have completely ignored the clear directives of the applicable regulation and general instructions for over sixteen years, the Medicare Program now lacks consistency, predictability, and fair notice to affected parties of what the law is for measuring the reasonableness of claimed owners' compensation. The existing system of *ad hoc* adjustments made under methodologies selected by local, nongovernmental subcontractors without adequate supporting data is really no system

at all. Serious questions are presented as to whether the Respondents are administering the Medicare Program in a fair, impartial, and competent manner.

The present system for making owners' salary adjustments requires Total Care and every other provider around the country to pursue their claims for reimbursement through the full administrative process in every year in which an owners' salary adjustment is made. Such case-by-case adjudication greatly burdens the administrative system and ignores that fact that the Secretary chose to address the owners' compensation issue back in 1966 through formal rulemaking - those regulations have never been formally repealed, they have been simply ignored by the administrative agency and its subcontractors. In its complaint, Total Care requested that the District Court order the Secretary and Intermediary to conduct surveys and establish valid compensation ranges, or order the Secretary to delineate what constitutes "other appropriate means" to determine reasonable salary under the regulations.

The issue now before this Court arises because the District Court and Fourth Circuit both dismissed Total Care's case for failure to exhaust administrative remedies; however, there is no administrative remedy available to redress Total Care's claims. The Medicare Act gives a dissatisfied provider the right to a hearing before the PRRB; however, the Medicare Act strictly limits the PRRB's authority to reviewing the "intermediary's determination" of the amount owed to the provider and other matters "covered by" the cost report for the fiscal year in question. 42 U.S.C. §1395oo(f); 42 C.F.R. §§405.1801(a), 1835, 1869. The PRRB has no broad authority to order the Intermediary or the Secretary to follow applicable regulations and general instructions for making adjustments. Therefore, the PRRB, the sole administrative hearing body for providers under the Medicare Program, has no power to remedy Total Care's present claims.

Moreover, the Medicare Act expressly provides that judicial review over the PRRB's decision is subject to the limitations of the APA. 42 U.S.C. §1395oo(f). Under the APA, the scope of review on appeal from the PRRB is whether the Board's action was arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law, or unsupported by substantial evidence.

5 U.S.C. §706. The APA thus precludes the reviewing court from conducting a *de novo* analysis of the case before it. Because the PRRB cannot hear Total Care's present claims that the administrative agency has ignored its own rules, a court on appeal from the PRRB's decision is also precluded from hearing such claims. There is thus no opportunity for judicial review of Total Care's present claims through the Medicare administrative process.

According to 42 U.S.C. §1395ii, §405(h) is the law in Medicare cases only as "applicable" to Title II of the Social Security Act. Where it is unlawful to apply §405(h) to Title II, therefore, it is also unlawful to apply it to Title XVIII. In the present case, application of §405(h) to preclude judicial review of Total Care's claims where there is no other avenue for relief violates Total Care's rights under the Fifth Amendment to the Constitution, threatens the basic concept of judicial review over acts of the Executive Branch, allows Congress to delegate unreviewable authority to an administrative agency and its nongovernmental subcontractors, and authorizes a federal agency to promulgate rules which are binding on regulated parties but not on the agency or its functionaries.

This case is therefore important because of the fundamental constitutional questions presented for all parties regulated by any administrative agency in the United States. There is also a substantial amount of money at stake and, arguably, the government's actions create risks to the public health as well.

ARGUMENTS FOR ALLOWANCE OF WRIT

I. By Precluding Judicial Review Over Medicare Claims For Which There Is No Administrative Remedy, The United States Court Of Appeals For The Fourth Circuit Has Decided An Important Question Of Federal Constitutional Law Which Has Not Been, But Which Should Be, Settled By This Supreme Court.

The decision by the Fourth Circuit to dismiss Total Care's claims for lack of jurisdiction raises several important questions of federal constitutional law which should be addressed by this Supreme Court.

First, the Fourth Circuit's decision allows the Secretary and his subcontractors to ignore the Secretary's own rules for determining reasonable owner's compensation. There is a fundamental principle of law, however, that a regulatory agency, as well as a regulated party, is bound by the agency's rules. *United States ex. rel. Accardi v. Shaughnessy*, 347 U.S. 260 (1954); *Service v. Dulles*, 354 U.S. 363 (1957); *Yellin v. U.S.*, 374 U.S. 109 (1983); *Smith v. Resor*, 406 F.2d 141 (2d Cir. 1990).

Failure of an agency to follow its own rules is actionable notwithstanding any arguable law to the contrary. *United States ex. rel. Accardi v. Shaughnessy*, 347 U.S. 260; *Service v. Dulles*, 354 U.S. 363; *Yellin v. U.S.*, 374 U.S. 109; *see also Pacific Molasses Co. v. F.T.C.*, 356 F.2d 386 (5th Cir. 1966); *Smith v. Resor*, 406 F.2d 141; *Thomas Brooks Chartered v. Burnett*, 920 F.2d 634 (10th Cir. 1990). This issue is especially important in the present case where the federal agency involved purports to delegate its immunity from judicial review to nongovernmental entities.

Second, the Fourth Circuit's decision flies in the face of the principle that a valid exercise of rulemaking power must set forth an enforceable standard of conduct *in advance* of the imposition of sanctions upon any particular individual. *See Columbia Broadcasting System v. U.S.*, 316 U.S. 407, 418 (1942). The Fourth Circuit's decision thus ignores the constitutional concept of due process, which requires fair notice and an opportunity to comply. When an administrative agency publishes

rules, the agency's failure to follow such rules tends to cause unjust discrimination and denial of adequate notice to affected parties. *International House v. N.L.R.B.*, 676 F.2d 906 (2d Cir. 1982); *Montilla v. Immigration and Naturalization Service*, 926 F.2d 162 (2d Cir. 1991). This principle has been applied even where the rules in question are not official regulations, but are held out to the public as being applicable and are relied upon by the public — as are Medicare general instructions. *See U.S. v. Leahey*, 434 F.2d 7 (1st Cir. 1970); *Massachusetts Fair Share v. Law Enforcement Assistance Administration*, 758 F.2d 708, 711 (D.C. Cir. 1985), citing *Morton v. Ruiz*, 415 U.S. 199 (1974).

The Fourth Circuit's decision, in contrast, authorizes the Secretary's subcontractors to pick and choose various substantive procedures in the form of adjustment methodologies without regard for uniformity or fair notice to providers. The absurdity of this kind of administrative system, which gives providers no opportunity to comply with the rules to be applied ultimately in an individual case, was illustrated when the Intermediary changed methodologies for adjusting Total Care's FY 1987 owners' compensation *during* the PRRB hearing arising from its original adjustment. Clearly, a provider cannot conform its conduct in advance of an administrative proceeding under such a system.

At one time, the Fourth Circuit apparently recognized an agency's duty to uphold its own rules and procedures. The Fourth Circuit stated:

> An agency of the government must scrupulously observe rules, regulations, or procedures which it has established. When it fails to do so, its action cannot stand and courts will strike it down.

U.S. v. Heffner, 420 F.2d 809, 811 (4th Cir. 1970).

The third issue raised by the Fourth Circuit's present decision is that it appears to reject the notion that an administrative agency must perform its duties in an evenhanded and responsible manner. When Congress delegates a function to an administrative agency, an important element of congressional purpose is that the function be carried out sensibly and efficiently, which

has not happened in this case. *See Cablevision Systems Development Co. v. Motion Picture Association of America, Inc.*, 836 F.2d 599 (D.C.Cir. 1988), *cert. denied*, 487 U.S. 1235 (1988).

Because the Fourth Circuit's decision raises many fundamental issues of constitutional and administrative law which affect all parties subject to regulation in this country, the Petitioner respectfully appeals to the Supreme Court to accept its request for certiorari.

II. The Decision Of The Fourth Circuit That 42 U.S.C. §405(h) Is a Bar To Mandamus Where There Is No Other Forum For Relief Through The Administrative Process Conflicts With The Decisions Of The Court Of Appeals For The District Of Columbia Circuit And Several Lower Courts.

The Supreme Court of the United States has never decided the question of whether §405(h) precludes Mandamus in all Social Security cases and, to the same extent, in all Medicare cases. The Supreme Court has stated:

> We have on numerous occasions declined to decide whether the third sentence of §405(h) bars mandamus jurisdiction over claims arising under the Social Security Act, either because we have determined that jurisdiction was otherwise available under §405(g) . . . or because we have determined that the merits of the mandamus claims were clearly insubstantial.

Heckler v. Ringer, 466 U.S. 602, 616-617 (1984), citing *Califano v. Yamasaki*, 442 U.S. 682 (1979); *see also Mathews v. Eldridge*, 424 U.S. 319 (1976); *Norton v. Mathews*, 427 U.S. 524 (1979) (where the Court found it "unnecessary . . . to resolve the details of [the] difficult and perhaps close jurisdictional argument[]" over the availability of Mandamus in light of §405(h)).

In *Ringer*, a case cited by the Fourth Circuit in support of its decision to deny Mandamus over Total Care's claims, a group of Medicare beneficiaries challenged the Secretary's regulation and general instructions which denied coverage for

a certain surgical procedure. The government argued that the plaintiffs were barred from judicial review by 42 U.S.C. §405(g), which requires all claims for payment under the Social Security Act first to be presented to the Secretary. The Supreme Court agreed on grounds that "no writ of Mandamus could properly issue in this case . . . [as] respondents clearly have an adequate remedy in §405(g) for challenging all aspects of the Secretary's [actions] . . ." *Ringer*, 466 U.S. at 616-618.

In the present case, in contrast, §405(g) is *not* available because it has not been incorporated into the Medicare Act. 42 U.S.C. §1395ii; *South Windsor Convalescent Home, Inc. v. Mathews*, 541 F.2d 910, 912 (2d. Cir. 1976). Although individual beneficiaries may invoke §405(g) to obtain review of their Social Security claims, the section is not available for providers to pursue Medicare claims. Moreover, no other adequate remedy is available for providers because of the restrictions imposed on the PRRB and any court on review from the PRRB under 42 U.S.C. §1395oo, as explained above. There is nothing to be gained by postponing judicial review in the present case, as Respondents have not followed the applicable regulation and general instructions for over sixteen years.

The important issue which remains after *Ringer*, therefore, is whether Congress may preclude Mandamus jurisdiction in Medicare cases where there is no administrative avenue for relief from an agency's blanket disregard of its own rules. The Fourth Circuit has decided this critical question of law in the affirmative; however, the constitutionality of such a decision is an important question of law which has not been - but which should be - settled by this Supreme Court.

The Fourth Circuit has even acknowledged the Supreme Court's failure to decide the scope of preclusion under §405(h). In *Monger v. Bowen*, 817 F.2d 15 (4th Cir. 1987), the Fourth Circuit stated:

> The Supreme Court has explicitly declined to decide whether this provision [§405(h)] prohibits the exercise of mandamus jurisdiction in cases involving social security disability benefits.

Monger, 817 F.2d at 17, citing *Ringer*, 466 U.S. 602.

Courts in other circuits have held that §405(h) is *not* a bar to Mandamus in cases where there is no other forum for relief. In *McMahon v. Califano*, 476 F. Supp. 978 (D. Mass. 1979), for instance, a district court in Massachusetts granted an order to compel the Secretary of Health, Education and Welfare (now HHS) to provide payments for nursing home services rendered to a Medicare patient who had been erroneously placed in a non-Medicare certified bed at a nursing home and denied coverage. While the court commented that the "availability of federal question jurisdiction in cases involving the Social Security Act is far from clear," it held that Mandamus jurisdiction was proper in the case.

The *McMahon* court stated:

> Minimally, the Secretary has a duty to comply with the regulations he has established, hence "[a] violation of a governmental agency's own regulations can be the basis for 1361 jurisdiction."

McMahon, 476 F.-Supp. at 982, quoting *Anderjar v. Weinberger*, 69 F.R.D. 690, 693-694 (S.D.N.Y. 1976).

The *McMahon* court also stated that, while the Supreme Court had not decided whether §405(h) precludes review under the Mandamus statute, lower courts had determined it does not. *McMahon*, 476 F. Supp. at 983, citing *Mathews v. Eldridge*, 424 U.S. 319, and *Elliot v. Weinberger*, 564 F.2d 1219 (9th Cir. 1977), *aff'd in part, rev'd in part on other grounds sub. nom., Califano v. Yamasaki*, 442 U.S. 682 (1979).

The court in *McMahon* adopted the Supreme Court's position as stated in *Elliot* that:

> [T]here is no evidence which indicates that Congress sought to limit mandamus at all by Section 405(h). In fact, Section 405(h) was enacted before Section 1361 [Mandamus] and apparently the subsequent enactment of Section 1361 did not evidence an intent that it be subject to any limiting statutes. Furthermore, Congress has specifically amended a limiting statute

> in at least one other instance when Congress intended such a limitation to apply to Section 1361 [in the context of judicial review of decisions by the Veterans Administration]. In our opinion then, Section 405(h) of Title 42 does not bar the exercise of mandamus jurisdiction in this action.

McMahon, 476 F. Supp. at 984 and 984, n.6; also citing *Caswell v. Califano*, 435 F. Supp. 127 (D. Me. 1977), *aff'd*, 583 F.2d 9 (1st Cir. 1978).

Similarly, in *Ganem v. Heckler*, 746 F.2d 844 (D.C. Cir. 1984), the Court of Appeals for the District of Columbia Circuit issued a writ of Mandamus against the Secretary because it found a "clear abnegation of the Secretary's statutory responsibilities." *Ganem*, 746 F.2d at 848. In declining to find §405(h) a bar to Mandamus, the *Ganem* court stated that the Supreme Court had explicitly reserved judgment on the issue at least four times. *Ganem*, 746 F.2d at 852, citing *Ringer*, 466 U.S. 602, *Califano v. Yamasaki*, 442 U.S. 682, *Mathews v. Eldridge*, 424 U.S. 319, and *Norton v. Mathews*, 427 U.S. 524.

The *Ganem* court continued, however, that:

> [T]here is now an unfractured consensus in the Courts of Appeals that have considered the question that Mandamus remains available under the Act in appropriate circumstances.

Ganem, 746 F.2d at 850, citing *Lopez v. Heckler*, 725 F.2d 1489, 1507-1508 (9th Cir. 1984), *Belles v. Schweiker*, 720 F.2d 509, 511-513 (8th Cir. 1983), *Starnes v. Schweiker*, 715 F.2d 134, 141-142 (4th Cir. 1983), *vacated on other grounds sub. nom. Starnes v. Heckler*, 467 U.S. 1223 (1984), *cert. denied,* 471 U.S. 1017 (1985), *Ellis v. Blum*, 643 F.2d 68 (2d Cir. 1981), *Martinez v. Richardson*, 472 F.2d 1121, 1125-1126 (10th Cir. 1983), and *Matos v. Secretary of HEW*, 581 F.2d 282, 286 n.6 (1st Cir. 1978).

Other courts have left open the possibility of Mandamus without deciding the question. In *Trinity Memorial Hospital v. Associated Hospital Service*, 570 F.2d 660 (7th Cir. 1977), for instance, the Court of Appeals for the Seventh Circuit declined to accept federal question jurisdiction over a hospital's challenge

to the accounting method used by the Intermediary in reviewing the hospital's cost report. The court commented in dicta, however, that 28 U.S.C. §1361, Mandamus, was a statutory provision *not* included in the last sentence of §405(h). *Trinity*, 570 F.2d at 666, n.8.

As there is conflict among the circuits on this important question of the availability of Mandamus in the absence of an administrative remedy, Petitioner respectfully requests this Court to grant its petition for certiorari and resolve this matter.

III. The Decision Of The Fourth Circuit That 42 U.S.C. §405(h) Is a Bar To Federal Question Jurisdiction Where There Is No Other Forum For Relief Through The Administrative Process Conflicts With The Decisions Of The Courts Of Appeals For The First, Second, Sixth, Eighth, And District Of Columbia Circuits.

Although this Supreme Court has not squarely addressed the matter, it has suggested that Federal Question jurisdiction is available in certain cases despite §405(h). In *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), the Supreme Court accepted Federal Question jurisdiction over Medicare claims involving matters outside the scope of benefits determinations made by Medicare Part B carriers. *See also Karnak Educational Trust v. Bowen*, 821 F.2d 1517 (11th Cir. 1987); *American Ambulance Service of Pa., Inc. v. Sullivan*, 911 F.2d 901 (3d Cir. 1991). The Supreme Court's holding suggests that the courts also have Federal Question jurisdiction over Medicare Part A and B claims involving matters outside the scope of PRRB reimbursement determinations.

In *Michigan Academy*, an association of family physicians challenged the validity of a Medicare regulation which awarded preferential payments for services performed by board certified practitioners. The government argued that, under the Medicare Act, an individual aggrieved by insufficient payment under Part B is granted an opportunity for a "fair hearing" by the carrier. *See* 42 U.S.C. 1395u(b)(3)(C). In light of §405(h), the government asserted, the plaintiffs were "forbidden [from] judicial review of all questions affecting the amount of benefits payable under Part

B of the Medicare program." *Michigan Academy*, 476 U.S. at 669, 673.

The Supreme Court rejected the government's position that judicial review was unavailable for challenges to Part B regulations. The Court stated that the purpose of §405(h) was:

> to "assure that administrative exhaustion will be required." Respondents' attack on the regulation here is not subject to such a requirement because there is no hearing [i.e., because the carrier is only authorized to make benefits determinations], and thus, no administrative remedy to exhaust.

Michigan Academy, 476 U.S. at 679, n.8, citing *Weinberger v. Salfi*, 422 U.S. 749 (1974).

Similarly, Total Care's claims under Parts A and B of Medicare should not be subject to the requirement of administrative exhaustion because, as explained above, there is no administrative remedy to exhaust.

By precluding judicial review over Total Care's Medicare claims for which there is no administrative remedy, the Fourth Circuit has decided an important question of federal constitutional law which has not been settled by this Supreme Court. The Fourth Circuit's decision to dismiss Total Care's case has serious implications for all Medicare providers seeking to challenge aspects of the Program which are not subject to review by the PRRB. The decision also affects the rights of all highly regulated parties in this country subject to the authority of an administrative agency.

Other circuit courts of appeal have held either that Federal Question jurisdiction exists in Medicare cases or have left open the possibility for jurisdiction in appropriate circumstances where no other avenue for judicial review is available.

The Court of Appeals for the First Circuit held that, although §405(h) usually operates to bar review over Medicare provider reimbursement disputes:

> [a] possible exception to this jurisdictional bar might arise where a provider reimbursement dispute pres-

> ented a colorable constitutional claim and the Act provided *no available administrative process leading to judicial review.*

Hospital San Jorge, Inc. v. U.S., 598 F.2d 684, 686 (lst Cir. 1979) (emphasis supplied).

The Court of Appeals for the Second Circuit stated that:

> We doubt the Supreme Court intended its reading of §405(h) in *Salfi* to have the effect of precluding federal jurisdiction over constitutional questions since the result would be at odds with the well established principle that a court will not construe a statute to restrict [] access to judicial review unless Congress manifests its intent to do so by "clear and convincing evidence."

South Windsor Convalescent Home, 541 F.2d at 913-914 (emphasis supplied), citing *Weinberger v. Salfi*, 422 U.S. 749, *Johnson v. Robinson*, 415 U.S. 361, 373-374 (1974), *Abbott Laboratories v. Gardner*, 387 U.S. 136, 141 (1967), and *Rusk v. Cort*, 369 U.S. 367, 379-380 (1962); *see also, U.S. v. Aquavella*, 615 F.2d 12, 20-21 (2d Cir. 1979), *modified on reh'g* (2d Cir. 1980).

The Court of Appeals for the Sixth Circuit commented:

> It would raise grave constitutional doubts if we held that the Secretary had unreviewable discretion in reimbursing Medicare providers, particularly if this discretionary authority was delegable to private parties. . . *Section 405(h) is incorporated into the Medicare Act "as applicable" . . . This subsection does not have a meaningful application in a case where no statutory review mechanism is available*, for the purpose of §405(h), following *Salfi*, is "simply the enforcement of the Section 405(g) procedures and prerequisites to judicial review . . ." We cannot believe that Congress intended in 1965 that Medicare providers would be "entitled" to whatever reimbursement the Secretary (or fiscal Intermediary) granted, be it high [] or low, fairly or unfairly set . . . Yet making provider reimbursements unreviewable would doubtless chill

> the provision of care to beneficiaries, or perhaps worse, would encourage providers to cheapen the care given to Medicare patients. More scrupulous providers might choose to offset insufficient Medicare reimbursement by charging higher fees to non-Medicare patients.

Chelsea Community Hospital v. Michigan Blue Cross Association, 630 F.2d 1131, 1135-1136 (6th Cir. 1980) (emphasis supplied), citing *Johnson v. Robinson*, 415 U.S. at 366-367, *St. Louis University v. Blue Cross Hospital Service*, 537 F.2d 283, 291-292 (8th Cir.), *cert. denied*, 429 U.S. 977 (1976), and *Whitecliff, Inc. v. U.S.*, 536 F.2d 347, 350 (Ct. Cl. 1976), *cert. denied*, 430 U.S. 969 (1977).

Similarly, the Court of Appeals for the Eighth Circuit has stated:

> *The Supreme Court has recognized that totally precluding judicial consideration of constitutional issues raises serious constitutional problems . . . Those constitutional problems are greatly intensified when an agency purports to delegate its immunity from judicial review to a nongovernmental entity . . . [W]e find that Congress did not intend for §405(h)* to apply to the Medicare Act in such a manner as to completely bar judicial consideration of a claim of denial of due process.

St. Louis University, 537 F.2d at 291-292, citing *Salfi*, 422 U.S. at 762, and *Johnson v. Robinson*, 415 U.S. at 366 and n.8 (emphasis supplied).

The Court of Appeals for the District of Columbia Circuit has stated:

> Since *Salfi*, the various courts have grappled with the issue of whether section §405(h) precludes federal question jurisdiction when no alternative form of judicial review is available. [] *Every court that has considered the issue has agreed that section 405(h) should be read so as to permit some avenue of judicial review for constitutional claims.*

National Association of Home Health Agencies v. Schweiker, 690 F.2d 932, 939-941 (D.C. Cir. 1982), *cert. denied*, 459 U.S. 1205 (1983), quoting *St. Louis University*, 537 F.2d at 289 (emphasis supplied).

Other circuits have also recognized the grave constitutional question presented generally by a federal statute which purports to bar judicial review over colorable constitutional claims. *E.g. Thomas Brooks Chartered v. Burnett*, 920 F.2d at 643; *Community Action of Laramie County, Inc. v. Bowen*, 866 F.2d 347 (10th Cir. 1989).

Because of the conflict in the circuits on this important question of the availability of Federal Question jurisdiction in the absence of administrative alternatives, the Petitioner respectfully requests this Court to grant its petition for certiorari and resolve this issue.

CONCLUSION

For all of the foregoing reasons, Petitioner requests that this petition for certiorari be granted and the judgment of the Fourth Circuit reversed; alternatively, Petitioner requests that this Court give the matters raised herein its plenary consideration.

Respectfully submitted,

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March 20, 1992

APPENDIX

UNPUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

TOTAL CARE, INC., a North Carolina Corporation,

Plaintiff-Appellant,

v.

LOUIS W. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES; GAIL WILENSKY, Administrator of the Health Care Financing Administration; GEORGE R. HOLLAND, Regional Administrator Region IV-Health Care Financing Administration; JAMES C. HOLLOWAY, Executive Director, Department of Operations, Federal Programs, Blue Cross and Blue Shield Association; BLUE CROSS AND BLUE SHIELD ASSOCIATION; BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA,

Defendants-Appellees.

No. 91-1514

Appeal from the United States District Court
for the Western District of North Carolina, at Charlotte.
Robert D. Potter, Chief District Judge.
(CA-90-128-C-C-P)

Argued: October 2, 1991

Decided: December 23, 1991

Before WILKINSON, Circuit Judge, BUTZNER, Senior Circuit Judge, and MERHIGE, Senior United States District Judge for the Eastern District of Virginia, sitting by designation.

Affirmed by unpublished per curiam opinion.

COUNSEL

ARGUED: Charles F. MacKelvie, HINSHAW & CULBERTSON, Chicago, Illinois, for Appellant. Lawrence Michael Meister, Office of the General Counsel, DEPARTMENT OF HEALTH AND HUMAN SERVICES, Baltimore, Maryland, for Appellees. **ON BRIEF:** Marcia S. Handler, HINSHAW & CULBERTSON, Chicago, Illinois; Charles Johnson, MOORE & VAN ALLEN, Charlotte, North Carolina, for Appellant. Stuart Gerson, Assistant Attorney General, DEPARTMENT OF HEALTH AND HUMAN SERVICES, Baltimore, Maryland; Thomas J. Ashcraft, United States Attorney, James M. Sullivan, Assistant United States Attorney, Charlotte, North Carolina, for Appellees.

Unpublished opinions are not binding precedent in this circuit. See I.O.P. 36.5 and 36.6.

OPINION

PER CURIAM:

This case is before the court on an appeal by Plaintiff-Appellant Total Care, Inc. ("Total Care") from the district court's denial of its Motion to Alter and/or Amend the Judgment and Order Granting Defendants-Appellees' Motion to Dismiss. Total Care, a provider of home health care services, initiated this suit in an effort to block the Defendants from withholding or reducing Medicare payments to home health care agencies related to the compensation of agency executives, on grounds that doing so in the absence of valid federal guidelines for the compensation of home health care executives violated federal regulations and the due process guarantees of the Constitution. The district court dismissed the complaint on grounds that it

lacked subject matter jurisdiction. We concur and affirm the decision below.

I

Total Care is a North Carolina corporation that provides home health care in North Carolina and South Carolina. Most of its patients are Medicare beneficiaries, so Total Care receives the bulk of its income from reimbursement under the Medicare Program, Title XVIII of the Social Security Act. *See* 42 U.S.C. § 1395 et seq.

Defendants Sullivan, Wilensky and Holland are the federal officials responsible for administration of the Medicare Program pursuant to the Social Security Act, including payments to home health care providers compensated under the Medicare Program. The Blue Cross Defendants serve as the prime fiscal intermediary to providers under a contractual relationship with the U.S. Department of Health and Human Services ("HHS"), and Defendant Holloway is responsible for implementation of all reimbursement determinations in the Blue Cross System.*

Appellant brought this suit to enjoin the Defendants from retaining Medicare payments that Appellant asserted should have been released as compensation to its executives under Part A of the Medicare Act. Home health care providers are entitled to a reasonable compensation allowance for the services of their executives, as well as reimbursement for the "reasonable cost" or "customary charges" for their services to Medicare beneficiaries. The HHS intermediary, in this instance the Blue Cross Defendants, determines annual Medicare reimbursement amounts based on annual cost report submitted by providers.

Under the terms of the Medicare Act, if a provider disagrees with the intermediary's determination, it may request a hearing before the Provider Reimbursement Review Board (the "PRRB"). When the PRRB enters a final decision, a dissatisfied provider may file a federal civil action challenging the decision within 60 days of its issuance. If

*Because the interests of all Defendants appear to be identical, the Court will generally refer to the Defendants collectively as "Defendants."

instead of making a determination the PRRB finds that it lacks authority to decide a question of law or regulation relevant to the dispute, the provider may bring a federal civil action within 60 days of that determination. If the PRRB finds that it has jurisdiction over the matter, the provider may request an Expedited Judicial Review ("EJR") hearing for a formal determination by the PRRB of its authority to decide questions of law or regulation relevant to the controversy. The provider is responsible for submitting supporting documents and materials necessary for the PRRB to review the situation, after which the PRRB must make a written determination within 30 days as to whether it has authority to decide the relevant questions. If the PRRB fails to decide within the allotted 30 days, the provider may then bring a federal civil action within 60 days with respect to the dispute at issue in its hearing request.

In the instant case, Appellant repaid Defendants approximately $104,000 due to compensation adjustments made to its 1987, 1988 and 1989 cost reports following an audit performed by the Blue Cross Defendants. On October 16, 1989, Appellant requested an Expedited Judicial Review from the PRRB. The PRRB requested additional documentation, which Appellant submitted on February 21, 1990. Appellant filed this suit on April 25, 1990, before the requested EJR hearing was held. The PRRB later determined that it had authority over the dispute, held an EJR hearing on May 17, 1990, and denied Appellant's EJR request. The PRRB found that questions of fact existed and that the central issue concerned not the validity of a regulation but its interpretation.

Defendants' initial Motion to Dismiss was denied, but upon resubmission was granted for lack of subject matter jurisdiction.

II

Appellant first claims to establish federal subject matter jurisdiction through federal question jurisdiction. 28 U.S.C. § 1331 confers original jurisdiction in the district court of all civil actions arising under the Constitution, laws, or treaties of the United States. Appellant argues that Defendants failed to comply with HHS regulations that mandate a procedure to conduct surveys and develop ranges of reasonable compensation for home health care agency executives.

The last such surveys and ranges developed were prepared in 1974. Total Care argues that in the absence of valid, up to date ranges, compensation determinations are made without objective parameters of reasonableness and violate due process.

The Social Security Act provides at 42 U.S.C. § 405(h) that "[n]o action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter." The U.S. Supreme Court has held that § 405(h), as quoted above, bars federal question jurisdiction over suits for recovery of Social Security Benefits. *See Weinberger v. Salfi*, 422 U.S. 749, 756-57 (1974); *see also Heckler v. Ringer*, 466 U.S. 602 (1984). This Circuit, following the Supreme Court, has held that § 405(h) limits "[f]ederal jurisdiction over provider reimbursement disputes...to that specifically supplied by the Medicare Act itself, i.e., 42 U.S.C. § 1395oo," which requires a final decision by the PRRB before judicial review is available. *Hopewell Nursing Home, Inc. v. Schweiker*, 666 F.2d 34, 38 (4th Cir. 1981) (hereinafter "*Hopewell I*"). By initiating this suit before the PRRB had heard or decided its EJR request, Total Care failed to comply with the full procedures for administrative and judicial review under the Medicare Act.

In *Hopewell I* the court found that the plaintiff purported to state a constitutional claim in an attempt to avoid the § 405(h) jurisdictional prohibition, when in fact its goal was to increase its own reimbursement level under Medicare. *See also Hopewell Nursing Home, Inc. v. Keckler*, 784 F.2d 554, 557-58 (4th Cir. 1986) (hereinafter "*Hopewell II*"). The Court is in agreement with the district court below that "the facts of this case are on all fours with the facts from *Hopewell I* and *Hopewell II*." Memorandum of Decision and Order at 10 (January 7, 1991). The Court adopts the reasoning of the district court that Total Care's attempt to characterize this as an action to "enforce procedural regularities" is suspect because Total Care continues to dispute its reimbursements for 1987, 1988 and 1989. As the lower court observed, it appears that Total Care "may be attempting to use this lawsuit as a means to 'force the PRRB to place the case on its calendar' in an expedited fashion." Memorandum of Decision and Order, *supra*, citing Plaintiff's Complaint at 32 (April 25, 1990).

Given the unambiguous language of the statute and clear precedent in this Circuit and the Supreme Court, the Court concludes that Total Care's jurisdictional claim under § 1331 is meritless.

III

Appellant also seeks in this appeal to establish subject matter jurisdiction through mandamus jurisdiction. Under 28 U.S.C. § 1361, "[t]he district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereunder to perform." The Supreme Court has on numerous occasions declined to decide whether 28 U.S.C. § 405(h), permits mandamus jurisdiction in an action for Medicare benefits. *See Ringer*, 466 U.S. at 616.

As noted above and in the district court's Memorandum of Judgment and Order, in 1986 the Fourth Circuit confirmed in *Hopewell II* that a failure by plaintiffs to exhaust the available administrative remedies provided in § 1395 precludes mandamus jurisdiction. 784 F.2d at 558. The instant case does not present a compelling reason to reexamine our holding in *Hopewell II*, because mandamus jurisdiction, even if available, would be inappropriate. Mandamus is an extraordinary means of providing a remedy where a plaintiff has exhausted all other avenues of relief and the defendant owes him or her a clear, non-discretionary duty. *See Ringer*, *supra*. Appellant Total Care initiated this civil action before the PRRB had heard its Expedited Judicial Review request. The district court was correct in declining to find mandamus jurisdiction in light of Total Care's failure to exhaust available avenues of relief.

Based on the discussion above and adopting the reasoning of the district court, the Court is persuaded that federal subject matter jurisdiction over this dispute does not exist. Accordingly, the decision below is

AFFIRMED.

IN THE DISTRICT COURT OF THE UNITED STATES FOR THE WESTERN DISTRICT OF NORTH CAROLINA CHARLOTTE DIVISION C-C-90-128-M

TOTAL CARE, INC.,
Plaintiff,

vs.

LOUIS W. SULLIVAN, M.D., Secretary of Health and Human Services, *et al.*,
Defendants.

ORDER

After considering the jurisdictional arguments submitted by counsel, the court finds that it has jurisdiction over this case. Defendants' motion to dismiss is DENIED without prejudice to renewal.

The court has further determined that the discovery requests made by plaintiff are reasonably calculated to lead to the discovery of admissible evidence. Defendants' motion for a protective is therefore DENIED with prejudice.

Defendants are directed to comply in timely fashion with plaintiff's discovery requests.

This 6 day of September, 1990.

/s/JAMES B. MCMILLAN

James B. McMillan
United States District Judge

IN THE DISTRICT COURT OF THE UNITED STATES FOR THE WESTERN DISTRICT OF NORTH CAROLINA CHARLOTTE DIVISION
C-C-90-128-P

TOTAL CARE, INC., a North Carolina Corporation,
Plaintiff,

v.

LOUIS SULLIVAN, as Secretary of the United States Department of Health and Human Services; GAIL WILENSKY, as Administrator of the Health Care Financing Administration; GEORGE R. HOLLAND, as Regional Administrator Region IV-Health Care Financing Administration; JAMES C. HOLLOWAY, as Executive Director, Department of Operations, Federal Programs, The Blue Cross and Blue Shield Association; THE BLUE CROSS AND BLUE SHIELD ASSOCIATION; and BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA,
Defendants.

MEMORANDUM OF DECISION AND ORDER

THIS MATTER is before the Court on the renewed motion, filed November 14, 1990, of Defendant Louis W. Sullivan, Secretary of the United States Health and Human Services, to dismiss this action for lack of subject matter jurisdiction pursuant to Rule 12 (b) (1) of the Federal Rules of Civil Procedure. On November 23, 1990, Plaintiff filed a memorandum in opposition to Defendants' renewed motion to dismiss.

I. THE PARTIES.

Plaintiff Total Care (hereinafter "Plaintiff") is a North Carolina corporation that provides home health care to patients whose doctors prescribe such treatment. The majority of the patients Plaintiff provides services to are covered by Medicare. Plaintiff provides services including nursing care, physical therapy, occupational and speech therapy, medical social services, and the services of a home health aide in both North Carolina and South Carolina.

Defendant Sullivan, as Secretary of the United States Department of Health and Human Services ("HHS"), is the Federal Officer responsible for the administration of the Medicare Program pursuant to the Social Security Act.[1] Defendant Wilensky, as the Administrator of HHS's Health Care Financing Administration ("HCFA"), is responsible for managing the payments to providers of services compensated by the Medicare Program. Defendant Holland is the regional administrator of HCFA, Atlanta, the region in which Plaintiff is located. Defendant Holloway is the official responsible for implementation of all reimbursement determinations in the Blue Cross System. The Blue Cross Defendants have a contractual relationship with HHS serving as the prime fiscal intermediary to providers such as Plaintiff.

II. PROCEDURAL AND FACTUAL BACKGROUND.

On April 25, 1990, Plaintiff filed the complaint which is the subject of this matter. The case was originally assigned to the Honorable James B. McMillan through a random assignment procedure utilized by the Clerk's office.

In the complaint, Plaintiff seeks to have the Court enjoin Defendants from withholding, retaining, offsetting or reducing Medicare payments related to the compensation of Plaintiff's home health agency executives. The home services payments at issue in this lawsuit fall within Part A of the Medicare Act. *See* 42 U.S.C. §§ 1395c-1395i-2. Plaintiff, as a provider of home services in the Medicare program, is to be paid the lesser of the

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[1] Because the Interests of all Defendants appear to be identical, the Court will refer to the Defendants collectively as "Defendants".

"reasonable cost" or the "customary charges" for services furnished to Medicare beneficiaries. *See* 42 U.S.C. § 1395f (b) (1). A provider may also be compensated a reasonable allowance for the services of its executives. *See* 42 C.F.R. § 413.5 (c) (8) (1989).

The annual Medicare reimbursement owed to the provider is determined after the close of the provider's fiscal year in a cost report. *See* 42 C.F.R. § 405.1801 (1989). The intermediary, in this case the Blue Cross Defendants, then analyzes the report, auditing it if it necessary, and issues a "notice of program reimbursement" (NPR) setting forth the final determination of the total amount of reimbursement due. *See* 42 C.F.R. § 405.1803 (1989). If a provider disagrees with the intermediary's determination, it may request a hearing before the Provider Reimbursement Review Board ("PRRB" or "Board"). *See* 42 U.S.C. § 1395oo(a).

Judicial review of a PRRB decision is not available until it is final. *See* 42 U.S.C. § 1395oo (f) (1). A civil action challenging a decision of PRRB must be filed in the United States District Court in which the provider is located or the District Court for the District of Columbia within 60 days of the provider being notified of the adverse decision. *Id.* However, when the Board determines that it is without authority to decide a question of law or regulation, the provider may commence a civil action within 60 days of the date on which such determination is rendered. *Id.* Moreover, after the Board determines that it has jurisdiction over the matter before it, the provider may request an Expedited Judicial Review (EJR) hearing for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy. *Id.* After supporting documents and materials necessary for the Board to render a determination are submitted, the Board must make in writing within 30 days a determination regarding whether it has the authority to decide the question of law or regulation. *Id.* If the Board fails to make such a determination within the applicable period, the provider may bring a civil action within 60 days with respect to the matter in controversy contained in such request for a hearing. *Id.*

In this case, Plaintiff filed a cost report for the period ending December 31, 1987 with the Blue Cross Defendants. Initially, Defendants approved all of Plaintiff's claimed executive compensation and actually reimbursed Plaintiff for those claimed expenses. After the cost report was audited, however, the Blue Cross Defendants on September 18, 1989 issued an NPR for fiscal year 1987 containing an executive compensation adjustment totalling approximately $30,000.00 for alleged "unreasonable" or "unallowable" costs. Although an NPR for fiscal years 1988 and 1989 has not yet been prepared, the Medicare effect of the payments for those years is an overpayment of approximately $74,500.00 to Plaintiff, assuming the rationale of the 1987 NPR is used for the 1988 and 1989 reports. Therefore, Plaintiff has repaid Defendants $104,566.00 because of the compensation adjustments in the 1987 cost report and the adjustments made by Plaintiff in reference to the 1988 and 1989 reports.

On October 16, 1989, Plaintiff requested an Expedited Judicial Review from the Board. Thereafter, the Board requested Plaintiff submit additional documentation in support of the EJR request. On February 21, 1990, Plaintiff submitted the additional documents. Prior to the Board acting on Plaintiff's EJR request, the complaint in this matter was filed on April 25, 1990. After determining that it had jurisdiction over this matter, the Board conducted a hearing on Plaintiff's EJR request on May 17, 1990. On that same date, the Board denied the EJR request finding that there were "[q]uestions of fact to be decided, and that the central issue does not concern the validity of a law, regulation or HCFA ruling but whether a regulation was properly implemented." *See Defendants' Renewed Motion to Dismiss,* filed November 14, 1990, at 25.

On June 26, 1990, Defendants filed a motion to dismiss. After Plaintiff had responded, Judge McMillan entered a cursory four (4) sentence order on September 7, 1990 denying Defendants' motion to dismiss. Judge McMillan did not state on what basis he found there to be subject matter jurisdiction, but instead merely noted that "[t]he court finds that it has jurisdiction over this case." Thereafter, this matter was reassigned to the undersigned. On October 22, 1990, a superseding pretrial order was entered by the undersigned. That pretrial order authorized Defendant

to file the motion currently before the Court to reconsider the motion to dismiss. After carefully considering the arguments contained in the memorandums filed by the parties, the Court believes that Judge McMillan was in error in finding that subject matter jurisdiction lies in this case. Therefore, based on the rationale enunciated below, the Court believes that it must grant Defendants' motion to dismiss.

III. DISCUSSION.

Plaintiff has stated that subject matter jurisdiction lies in this Court based on four (4) grounds. A discussion of each follows.

A. Federal Question Jurisdiction under 28 U.S.C. § 1331.

Title 28, United States Code section 1331 confers original jurisdiction in the district court of all civil actions arising under the Constitution, laws, or treaties of the United States. Plaintiff claims that Defendants have failed to comply with its own regulations requiring it "[t]o conduct tri-annual surveys to determine the pertinent facts to be used by HCFA to formulate allowable ranges of owners' compensation". *See Plaintiff's Memorandum in Opposition to Defendants' Renewed Motion to Dismiss,* filed November 23, 1990, at 4. In the absence of such ranges, Plaintiff argues that there are no objective parameters for the Blue Cross Defendants as the intermediary to measure the reasonableness of each provider's claim for reimbursement of owners compensation. Accordingly, Plaintiff believes that the absence of regulatory guidance amounts to a denial of due process, and hence, jurisdiction under 28 U.S.C. § 1331 is appropriate.

In support of the renewed motion to dismiss, Defendants rely primarily on 42 U.S.C. § 405(h) in arguing that § 1331 is unavailable as a basis for subject matter jurisdiction in Medicare matters. Section 405(h) provides:

> (h) Finality of Secretary's decision. The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. *No action*

> *against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter* (emphasis added).

Defendants contend that the plain language of the statute prevents Plaintiff from relying on § 1331 in this case.

The United States Supreme Court has held that the third sentence of 42 U.S.C. § 405(h) bars district court federal question jurisdiction over suits which seek to recover Social Security benefits. *See Weinberger v. Salfi,* 422 U.S. 749, 756-57 (1974); *see also Heckler v. Ringer,* 466 U.S. 602 (1984). The third sentence of § 405(h) is more than a codified requirement of administrative exhaustion. *Salfi,* 422 U.S. at 757. *All* actions involving Social Security benefits brought under § 1331 are barred, not only those actions that have been brought in which administrative remedies have been exhausted. *Id.* Thus, even actions which allege that the Secretary of HHS abused his discretion by not promulgating regulations in violations of a provider's constitutional right to due process are not actionable under § 1331. *Id.* at 762. In justifying this holding, the Supreme Court noted, "[E]xhaustion is generally required as a matter of preventing premature interference with agency process, so that the agency may function efficiently and so that it may have an opportunity to correct its own errors, to afford the parties and the courts the benefit of this experience and expertise, and to compile a record which is adequate for judicial review." *Id.* at 765.

The law from the Supreme Court is clear—a provider's claim must be "channeled first into the administrative process which Congress has provided for the determination of claims for benefits". *See Ringer,* 466 U.S. at 614. The Fourth Circuit Court of Appeals has followed the Supreme Court in finding that § 405(h) limits "[j]udicial review of provider reimbursement disputes by means of the procedure available under the Medicare Act, that is, section 1395oo, which alone specifies the administrative procedures culminating in judicial review of reimbursement disputes." *Hopewell Nursing Home, Inc. v. Schweiker,* 666 F.2d 34, 38 (4th Cir. 1981) (hereinafter "*Hopewell I*"). Absent resort to the Act's procedures, the providers cannot seek to have their claims resolved by the district court. *Id.* The court in *Hopewell I* found that an attempt to cloak a claim in constitutional garb when the plaintiff actually sought to increase the amount of its

reimbursement fell within the § 405(h) prohibition against invoking § 1331 jurisdiction. *Id.* at 39. "[W]e therefore refuse to allow Hopewell to rescue its case from the strictures of *Salfi* and (section 405(h)) merely by grouping its claims under the rubric of constitutional or statutory challenge". *Id.* at 40; *see also Hopewell Nursing Home, Inc., v. Heckler,* 784 F.2d 554, 557-58 (4th Cir. 1986) (hereinafter "*Hopewell II*").

The Court believes that the facts of this case are on all-fours with the facts from *Hopewell I* and *Hopewell II*.[2] Plaintiff has attempted to characterize this action as "[n]ot a claim for benefits, but rather an action to enforce procedural regularities". *See Plaintiff's Complaint,* filed April 25, 1990, at par. 6 on page 3. However, this characterization is suspect due to Plaintiff's belief that "[t]he compensation claimed for fiscal years 1987, 1988 and 1989 for its Executive Director was in fact reasonable and reimbursable under the Medicare Act . . . ." *Id.* at par. 55 on page 24. Moreover, it appears to the Court that Plaintiff may be attempting to use this lawsuit as a means to "force the PRRB to place the case on its calendar" in an expedited fashion. *Id.* at par. 68 on page 32. Given the unambiguous language of the statute and the clear Supreme Court and Fourth Circuit interpretations of the statute, the Court concludes that Plaintiff's jurisdiction claim under § 1331 is meritless.[3]

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[2] Defendants have cited an unpublished decision from the Eastern District of North Carolina that is remarkably similar to this case. *In Comprehensive Home Health Care I v. Sullivan,* No. 90-9-Civ-7 (E.D.N.C. June 22, 1990), the plaintiff brought an action in district court challenging the decision of the Secretary to adjust the costs of executive compensation. However, the plaintiff did not exhaust all of its administrative remedies prior to filing the action. Judge Britt rejected the plaintiffs claim that it could bypass the administrative remedies by seeking to compel the Secretary to explain the procedures the intermediary should follow in computing the allowable cost for owner's compensation. *Id.* at 5.

[3] In its response to Defendants' renewed motion to dismiss, Plaintiff argues that the recent Supreme Court case of *Bowen v. Michigan Academy of Family Physicians,* 476 U.S. 667 (1986) has changed the Medicare law in the Supreme Court and the Fourth Circuit. As Defendants note, however, that case involved the beneficiary's right to judicial review of Constitutional claims under Part B of the Medicare Act. Part B does not contain an express statutory right to judicial review. In Part A, which alone is applicable to this case, the exclusive judicial review provisions are clearly set forth in the statute. Therefore, *Michigan Academy* is distinguishable from this case.

B. Mandamus Jurisdiction Under 28 U.S.C. § 1361.

The federal mandamus statute is codified at 28 U.S.C. § 1361. That statute provides:

> The district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereunder to perform.

The Supreme Court has not yet decided whether the effect of the third sentence of § 405(h) makes mandamus jurisdiction available in an action for Medicare benefits. *See Ringer,* 466 U.S. at 616. However, in a case decided after *Ringer,* the Fourth Circuit held that a failure by plaintiffs to exhaust the available administrative remedies provided in § 1395oo precludes mandamus jurisdiction. *See Hopewell II,* 784 F.2d at 558. Given the Clear language of *Hopewell II,* the Court would be reluctant to find absent explicit language to the contrary in another Fourth Circuit case that mandamus jurisdiction is available in Medicare cases.[4]

Even if mandamus jurisdiction was not precluded in this Circuit in Medicare cases, the Court would not issue a writ of

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[4] In arguing that the status of the law is unsettled in the Fourth Circuit concerning mandamus jurisdiction in Medicare cases, Plaintiff cites to the case of *Monger v. Bowen,* 817 F.2d 15 (4th Cir. 1987). The Fourth Circuit, in a footnote, stated that the Supreme Court has explicitly declined to decide whether mandamus jurisdiction can lie in Medicare cases. *Id.* at 17, note 2. The court cited cases from two other circuits in which courts held that § 405 (h) does not preclude mandamus jurisdiction. *Id.* The court then stated, "[W]e find it unnecesary to determine the propriety of mandamus jurisdiction in Monger's case, since we base our decision on the explicit language of 20 C.F.R. § 404.988 (a) (1986)." *Id.*

Naturally, Plaintiff argues that this language indicates that the Fourth Circuit has reversed its previous decision in *Hopewell II.* The Court on the other hand believes that the language only indicates that the Fourth Circuit declined to address the mandamus jurisdiction issue before it. Such language can hardly be considered persuasive evidence that the court has reversed the clear holding of *Hopewell II* that a failure by plaintiffs to exhaust the available administrative remedies provided in § 1395oo precludes mandamus jurisdiction. *See Hopewell II,* 784 F.2d at 558. The Court will leave it to the Fourth Circuit to explicitly reverse its previous holdings.

mandamus in this case. The extraordinary writ of mandamus is intended to provide a remedy for a plaintiff only if he has exhausted all other avenues of relief and only if the defendant owes him a clear non-discretionary duty. *See Ringer,* 466 U.S. at 616; *Kerr v. United States District Court,* 426 U.S. 394, 402-403 (1976). In this case, Plaintiff clearly has not exhausted all of its other avenues of relief. Plaintiff filed this action *prior* to the hearing by the PRRB. Obviously, Plaintiff had available to it the remedy of awaiting the Board's decision prior to filing this action. Thus, the Court does not believe that Plaintiff has exhausted all of the administrative remedies available. Moreover, the Court simply cannot characterize this case as "extraordinary". Therefore, even if the Court had the authority to do so, it would not issue a writ of mandamus in this case.

C. Jurisdiction Under the All Writs Act; 28 U.S.C. § 1651.

As noted by Defendants, the All Writs Act may be the basis for the authority to issue an injunction, but it is not a basis of jurisdiction. *See Defendants' Memorandum in Support of the Renewed Motion to Dismiss,* filed November 14, 1990, at 19 (citing *Brittingham v. Commissioner,* 451 F.2d 315, 317 (5th Cir. 1971). Therefore, subject matter jurisdiction cannot be established under this argument.

D. Jurisdiction under the Expedited Judicial Review Provision of the Medicare Act; 42 U.S.C. § 1395oo.

Title 42, United States Code section 1395oo(f)(1) requires that a provider exhaust the administrative remedies available to it prior to initiating an action in the district court. By its own admission, Plaintiff filed this action prior to the PRRB hearing.[5] Nonetheless, Plaintiff contends that jurisdiction under § 1395oo is available in this case because the Board did not conduct an EJR within 30 days after the hearing was requested by Plaintiff. Thus, Plaintiff argues that because the Board did not respond in a timely fashion, § 1395oo(f)(1) provides that "a civil action may be filed (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing". *See* 42 U.S.C. § 1395oo(f)(1).

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[5] The Court is informed that the hearing before the PRRB is scheduled for early January, 1991.

Under the applicable regulation promulgated by Defendants, the thirty day period does not begin to run until after the Board determines it has jurisdiction to entertain the matter. *See* 42 C.F.R. § 405.1842(b)(3). The regulation is consistent with the statutory provision contained in § 1395oo(f)(1) which provides in pertinent part:

> *If a provider of services may obtain a hearing under subsection (a) of this section* . . ., such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations . . . . The Board shall render such determination in writing within thirty days after the Board receives the request *and accompanying documents and materials* . . . (emphasis added).

The statute indicates that a two-step process must be completed by the Board. *See Alexandria Hospital v. Bowen*, 631 F Supp. 1237, 1244 (W.D. Va. 1986). First, the Board must determine if it has jurisdiction over an appeal. This determination is not governed by the thirty day time period of the EJR. *Id.* Only after the Board determines it has jurisdiction over the matter does the thirty day period begin to run in the Board's consideration of the EJR. Furthermore, the thirty day period does not begin to run until *after* the Board receives any accompanying documents and materials from the provider.

In this case, Plaintiff filed a request for an EJR on October 16, 1989. The accompanying documents and materials submitted by Plaintiff were not received until February 21, 1990. On May 17, 1990, the Board determined it had jurisdiction over this matter. On the same date, the Board denied Plaintiff's request for an EJR. Thus, the determination was rendered on the same day (and, thus, within thirty days) that the Board determined it had jurisdiction.

Plaintiff urges this Court to nullify Defendants' regulation concerning the determination of when the thirty day period begins to run. The Court believes that the regulation is consistent with the statute. This Court agrees with Judge Turk's following conclusion regarding a similar argument:

> [W]hile Congress has clearly imposed a 30-day limit on the PRRB's evaluation of EJR requests, no such limits have been placed on the PRRB's evaluation of its jurisdiction. In the absence of such a Congressional limitation, this court is unwilling to enforce one. *Id.*

Furthermore, the legislative history of the statute indicates that the purpose of the EJR provision was solely to expedite the resolution of the legal controversies in Medicare reimbursement appeals that the Board was unable to hear. *Id.; see also* H.R. Rep. No. 96-1167, *reprinted in* 1980 U.S. Code Cong. & Ad. News at 5757. The EJR provision, contrary to Plaintiff's assertion, was not intended to create a new basis for subject matter jurisdiction. *Id.*

The simple conclusion to Plaintiff's request that the Court find subject matter jurisdiction lies under § 1395oo(f)(1) is for the Court to point out that Plaintiff failed to file its action within sixty days of time in which it claims the EJR request was made. If the Court was inclined (which it is not as indicated above) to adopt Plaintiff's argument that the thirty day period for the Board to rule on the EJR request began to run the date the request was made, the Board would have had to rule on the request no later than Novermber 16, 1989. Under this analysis, however, Plaintiff would have had to file its action sixty days from the time the request was made. Thus, the action would have had to been filed no later than January 15, 1990. The complaint in this matter was actually filed on April 25, 1990; more than sixty days from the date suggested by Plaintiff as the correct commencement date for the sixty day period to begin to run.

For the reasons stated herein, the Court does not believe Plaintiff's argument is meritorious that subject matter jurisdiction is available under the EJR provision of § 1395oo(f)(1).

IV. CONCLUSION.

As indicated above, the Court does not believe that subject matter jurisdiction based on any of the four (4) grounds presented by Plaintiff lies in this Court. Accordingly, the Court will grant Defendants' motion to dismiss.

V. ORDER OF THE COURT.

NOW, THEREFORE, IT IS ORDERED that the renewed motion of Defendant Louis W. Sullivan, Secretary of the United States Health and Human Services, to dismiss this action for lack of subject matter jurisdication pursuant to Rule 12(b)(1) of the Federal Rules of Civil Procedure be, and hereby is, GRANTED AS TO ALL DEFENDANTS. This matter is hereby DISMISSED.

This the 7th day of January, 1991.

/s/ ROBERT D. POTTER

ROBERT D. POTTER, CHIEF
UNITED STATES DISTRICT JUDGE

IN THE DISTRICT COURT OF THE UNITED STATES FOR THE WESTERN DISTRICT OF NORTH CAROLINA CHARLOTTE DIVISION C-C-90-128-P

TOTAL CARE, INC., a North Carolina Corporation,
Plaintiff,

v.

LOUIS SULLIVAN, as Secretary of the United States Department of Heatlh and Human Services; GAIL WILENSKY, as Administrator of the health Care Financing Administration; GEORGE R. HOLLAND, as Regional Administrator Region IV-Health Care Financing Administration; JAMES C. HOLLOWAY, as Executive Director, Department of Operations, Federal Programs, The Blue Cross and Blue Shield Association; THE BLUE CROSS AND BLUE SHIELD ASSOCIATION; and BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA,
Defendants.

JUDGMENT

In accordance with the Memorandum of Decision and Order filed simultaneously with the filing of this Judgment,

IT IS ORDERED, ADJUDGED, AND DECREED THAT:

(1) Defendants' renewed motion to dismiss be, and hereby is, GRANTED;

(2) This matter be, and hereby is DISMISSED WITHOUT PREJUDICE with leave granted for Plaintiff to refile this action following the exhaustion of all administrative remedies; and

(3) Each party shall bear its and their own cost.

This the 8th day of January, 1991.

/s/ ROBERT D. POTTER

ROBERT D. POTTER, CHIEF
UNITED STATES DISTRICT JUDGE

IN THE DISTRICT COURT OF THE UNITED STATES FOR THE WESTERN DISTRICT OF NORTH CAROLINA CHARLOTTE DIVISION C-C-90-128-P

TOTAL CARE, INC., a North Carolina Corporation,

Plaintiff,

v.

LOUIS SULLIVAN, as Secretary of the United States Department of Health and Human Services; GAIL WILENSKY, as Administrator of the Health Care Financing Administration; GEORGE R. HOLLAND, as Regional Administrator Region IV-Health Care Financing Administration; JAMES C. HOLLOWAY, as Executive Director, Department of Operations, Federal Programs, The Blue Cross and Blue Shield Association; THE BLUE CROSS AND BLUE SHIELD ASSOCIATION; and BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA,

Defendants.

ORDER

THIS MATTER is before the Court on Plaintiff's motion, filed January 17, 1991, to alter and/or amend the judgment under Rule 59 of the Federal Rules of Civil Procedure and to stay enforcement of the judgment pending disposition of the aforesaid motion pursuant to Rule 62(b) of the Federal Rules of Civil Procedure. On January 30, 1991, Defendants filed a response to Plaintiff's motion to alter or amend the judgment.

In its original Order of January 8, 1991 in which the Court dismissed Plaintiff's complaint for lack of jurisdiction, the Court

attempted to address at length each basis of jurisdiction alleged by Plaintiff. The Court found that it did not have jurisdiction based on clear Fourth Circuit precedent.

Plaintiff's present motion is nothing more than a rehashing of the previous arguments made. Consistent with its previous practice, Plaintiff has failed to address in a meaningful manner the Fourth Circuit cases which this Court believes that it is bound by. Therefore, the Court continues to believe based on the rationale cited in the Court's Order of January 8, 1991 that jurisdiction does not lie in this manner until Plaintiff exhausts its administrative remedies. Because Plaintiff has failed to exhaust those administrative remedies, the Court will not amend or alter the judgment previously entered in this case.

NOW, THEREFORE, IT IS ORDERED that Plaintiff's motion to alter and/or amend the judgment under Rule 59 of the Federal Rules of Civil Procedure and to stay enforcement of the judgment pending disposition of the aforesaid motion pursuant to Rule 62(b) of the Federal Rules of Civil Procedure be, and hereby is, DENIED.

This the 6th day of March, 1991.

/s/ ROBERT D. POTTER

ROBERT D. POTTER,
UNITED STATES DISTRICT JUDGE

PROVIDER REIMBURSEMENT MANUAL - CHAPTER 9 COMPENSATION OF OWNERS

Principle (Prov. Reimb. Man., Part I, § 900)

A reasonable allowance of compensation for services of owners is an allowance cost, provided the services are actually performed in a necessary function (§ 405.426 [redesignated as 413.102. . .] of Regulation 5 of the Social Security Administration).

Application (Prov. Reimb. Man., Part I, § 901)

The allowance of compensation for services of sole proprietors and partners is the reasonable value of the services rendered. The test of reasonableness applies to the actual compensation of all individuals performing services in connection with the operation of a provider including: (1) employees, officers, and directors owning stock in closely-held corporations; (2) employees, officers, and directors with a substantial ownership or equity in public corporations; and (3) certain employees of trusts (see § 902.6).

DEFINITIONS

(Prov. Reimb Man., Part I, § 902)

* * * * *

Compensation - Corporations (Prov. Reimb. Man., Part I, § 902.2)

For purposes of determining whether the total compensation paid to an owner is reasonable, compensation as defined herein means remuneration paid to an owner regardless of the form in which it is paid. (See sections 906 and 906.1) Compensation may be included in allowable provider cost only to the extent that it respresents reasonable remuneration for managerial, administrative, professional, and other services related to the operation of the facility and rendered in connection with patient care. Services rendered in connection with patient care include both direct and indirect activities in the provision and supervision of patient care, such as administration, management, and supervision of the overall institution. Services which are not related to either direct or indirect patient care, e.g., those primarily for the purpose of managing or improving the owner's financial

investment, are not recognized as an allowable cost. Compensation of a physician-owner of a facility is subject to an allocation between professional and provider components (see § 2108).

Payments found to represent a return on equity capital are not compensation and are in no event allowable as an item of reimbursable cost. Nor are such payments considered as compensation for purposes of determining the reasonable level of reimbursement of the owner.

Reasonableness (Prov. Reimb. Man., Part I, § 902.3)

Reasonableness requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable institutions depending upon the facts and circumstances of each case. Reasonable compensation is limited to the fair market value of services rendered by the owner in connection with patient care. Fair market value is the value determined by the supply and demand factors of the open market.

Necessary (Prov. Reimb. Man., Part I, § 902.4)

The requirement that the function be necessary means that had the owner not rendered the services, the institution would have had to employ another person to perform them. The services must be pertinent to the operation and sound conduct of the institution.

* * * * *

CRITERIA FOR DETERMINING REASONABLE COMPENSATION - GENERAL

(Prov. Reimb. Man., Part I, § 904)

In general, the determination as to the reasonableness of a person's compensation is made by comparing it with the compensation paid to other individuals in similar circumstances. To obtain uniformity in the application of the principle, the intermediary (1) identifies compensation paid to individuals other than owners by comparable institutions in the same geographical area, (2) furnishes this data to the Bureau of Health Insurance [now HHS] regional office where it is consolidated with data obtained by other intermediaries to produce ranges of reasonable

compensation to be used in the same area, and (3) applies a set of criteria based on the qualifications and responsibilities of the owner to determine his placement within the range.

In establishing the ranges, abnormally low amounts of compensation sometimes received by employees of religiously sponsored providers may be ignored since circumstances led to the establishment of their rate of pay which are not applicable to other persons. Although intermediaries are to be guided by the established ranges in evaluating the reasonableness of an owner's compensation, there may be special circumstances where an intermediary, on the basis of its judgment, allows an amount that is outside the established range. This might occur where the provider has certain characteristics or the owner has special qualifications and experience which would make a comparison with other institutions and individuals unrealistic.

Alternative means for obtaining salary data on nonowners - In some cases a regional office may find it possible to obtain the necessary nonowner salary data without conducting intermediary surveys. Such alternative sources might include state nursing home associations (and other provider associations), and state health and welfare agencies. The regional office might also wish to utilize these alternative sources to supplement the data obtained through intermediary surveys. The regional office will advise the intermediaries if surveys shall be deemed unnecessary. *Medicare Intermediary Manual,* HIM-13 (Part 2), § 2120.1.

* * * * *

Intermediary responsibilities - Intermediaries are responsible for (1) gathering data on the claimed compensation of owners of proprietary providers, (2) obtaining a complete description of the actual duties and qualifications of the owners, (3) obtaining information regarding the institution (its size, location, services offered, etc.), (4) obtaining information about the compensation paid nonowners for similar services, (5) furnishing nonowner compensation data classified by type of provider and position to the regional offices for use in establishing ranges of reasonable compensation, (6) applying the ranges of reasonable compensation, and (7) furnishing to the appropriate

regional office a monthly report concerning all owners' compensation decisions made. *Medicare Intermediary Manual,* HIM-13 (Part 2), § 2120.1.

* * * * *

Regional office responsibilities - The general responsibilities of the regional offices include the following: (1) ensuring that intermediaries obtain adequate salary data, (2) consolidating the salary data furnished by intermediaries into ranges of reasonable compensation for various positions by type of provider, (3) issuing ranges of reasonable compensation to intermediaries, (4) monitoring intermediary performance to assure that the ranges of compensation are being followed. *Medicare Intermediary Manual* HIM-13 (Part 2), § 2120.1.

Factors to Be Considered in Determining Comparability of Institutions (Prov. Reimb. Man., Part I, § 904.1)

There are a number of factors involved in the determination of the comparability of institutions which include, but are not necessarily limited to, the following:

A. The Size of an Institution - The size of institutions will generally be measured by the number of beds; however, because of differences in occupancy rates, in some situations the number of patient days for the period in question may also be used in determining whether particular providers are comparable in size. Where only a portion of the total beds of an institution are certified, the provider should be classified by the total beds available since the compensation paid administrators is based on services rendered to the entire facility. Only a portion of the allowed compensation would be allocated to the certified part of the institution. For home health agencies, size will be measured by the number of visits.

B. Classification of Institutions - Institutions should be classified by the type and range of services offered. The type of services has reference to the nature of the services rendered, i.e., medical, surgical, rehabilitative, etc. The range of the services means the extent to which the particular kind of service can be rendered. For example, for rehabilitative services, the range of services refers to the amount and kind of physical therapy

available, whether speech therapy is available, etc. In considering the type and range of services rendered, emphasis will be given to those services available in the institution rather than services which are available only when arranged for with other organizations by the provider.

C. Number and Types of Personnel Employed - This factor refers to the number of personnel employed in the various professional and nonprofessional categories.

D. Geographical Location - In determining the comparability of facilities, geographical location is a consideration. Since consideration is given to the area of the United States in which the institution is located and whether it is an urban, suburban or rural setting, differences in prevailing living and wage costs are recognized.

Factors to be Applied in Evaluating Compensation Within Range for Comparable Institutions (Prov. Reimb. Man., Part I, § 904.2)

The factors that are considered in determining the reasonableness of an owner's compensation within the range established for a class of institution include the following:

A. The qualifications of the owner including his educational attainment and experience in similar responsible positions. Education and experience are pertinent only as they relate to the job being performed and the services being rendered. Where an owner-administrator is also a physician, the services evaluated are administrative in nature rather than the actual practice of medicine. Therefore, the compensation allowed is based on the compensation non-physician administrators receive rather than on the rate physicians receive for their professional services.

B. The number and types of professional and other personnel supervised by the owner.

C. The duties and responsibilities of the owner and the actual services rendered.

1. Information as to the owner's actual duties, responsibilities, hours, and days regularly worked, etc., should be obtained. Compensation for "full-time" service requires that at least 40 hours per week be devoted to the duties of the position for which

compensation is requested. Owners devoting less than 40 hours per week to the position will be compensated on a proportionate basis, with 40 hours per week considered to be the full-time basis for such proportionate compensation.

2. The fact that an owner may have potential supervisory and managerial authority and responsibility for an institution is not as important as the manner in which this authority and responsibility is actually exercised. For example, another individual, perhaps with the designation of assistant administrator, might perform most day-to-day managerial and supervisory functions in an institution.

In such case, the right of the owner-administrator to overrule decisions does not constitute a basis for recognition of compensation comparable to administrators in other similar situations.

D. Whether the owner performs services for any other institutions or is engaged in any other occupation.

1. Presumably, where an owner performs services for several institutions he spends less than full time (i.e., at least 40 hours a week) with each institution. In such cases, allowable compensation shall reflect an amount proportionate to a full-time basis.

2. If an owner is engaged in another activity, such as an owner-administrator also having a private medical practice, he ordinarily could not render full-time services as administrator of the institution.

* * * * *

PROCEDURES FOR DETERMINING REASONABLE COMPENSATION

(Prov. Reimb. Man., Part I, § 905)

General (Prov. Reimb. Man., Part I, § 905.1)

Intermediaries have the responsibility for evaluating the reasonableness of an owner's compensation in terms of the criteria provided in sections 904.1 and 904.2. On the basis of information obtained by surveys of providers, ranges of compensation for comparable institutions will be established. Intermediaries will utilize these ranges both for final settlement and when setting interim rates.

Where an owner indicates he functions in an executive role other than as administrator (e.g., president, executive director, etc.), the intermediary will ascertain the owner's actual duties and categorize him by the nature of the services rendered in connection with patient care rather than by the various titles administrators might have. Intermediaries will consolidate virtually identical or similar services to permit the establishment of realistic ranges.

Where an owner occupies a position other than as administrator, (e.g., nursing supervisor) the determination of the reasonableness of the compensation may be much simpler since there would tend to be more uniformity in the type of service rendered in a position other than as an administrator.

* * * * *

Surveys (Prov. Reimb. Man., Part I, § 905.2)

Surveys shall include all proprietary institutions and a sufficient number of comparable nonproprietary institutions in the same geographical area so that an adequate comparison can be made. The comparison should take into consideration the services and compensation of non-owner administrators of proprietary and non-proprietary facilities.

Compensation of owners - Procedures for establishing ranges - A. General - To assist in evaluating the reasonableness of a claim for compensation to owners, ranges of reasonable compensation are established based upon surveys of administrative salaries paid to individuals other than owners in proprietary and nonproprietary providers. These surveys are conducted at 3-year intervals [sic, the last survey for which data was released was the 1974 survey], beginning in 1968. In intervening years, the ranges are updated to approximate changes in the fair market value of services rendered.

* * * * *

TYPES OF COMPENSATION - CORPORATIONS

(Prov. Reimb. Man., Part I, § 906)

As indicated in § 902.2, compensation for the necessary services of a stockholder-employee or an individual described in § 901 (other than sole proprietors and partners) includes:

1. Salary amounts paid for managerial, administrative, professional, and other services.

2. Amounts paid by the institution for the personal benefit of the owner.

3. The costs of assets and services which the owner receives from the institution.

4. Deferred compensation.

Any payments to an owner in excess of a reasonable level do not constitute compensation or any other allowable cost.

Other Types of Compensation (Prov. Reimb. Man., Part I, § 906.1)

There may be instances in which an owner is receiving compensation in a form that without close scrutiny might not be recognized as compensation (e.g., fringe benefits). Compensation to an owner may include: (1) supplies and services used for the personal use of the owner, (2) special merchandise ordered from wholesalers for the owner's personal use, (3) wages of a domestic or other employee who works in the home of the owner, (4) personal use of a car owned by the business, (5) personal insurance premiums paid for the owner, and other fringe benefits as described in § 2144 of this manual.

Any of the above payments must be included in the owner's total compensation to determine its reasonableness when such payments meet the requirements for being categorized as fringe benefits under the definition given in § 2144.1. If the requirements of that section are not met, these types of payments cannot be considered compensation.

* * * * *

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No. 91-1534

In the Supreme Court of the United States

OCTOBER TERM, 1991

TOTAL CARE, INC., PETITIONER

v.

LOUIS W. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENTS IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether the district court was precluded by 42 U.S.C. 405(h) from exercising federal question jurisdiction over claims arising under Part A of the Medicare Act.

2. Whether petitioner was entitled to a writ of mandamus under 28 U.S.C. 1361.

TABLE OF CONTENTS

	Page
Opinions below	1
Jurisdiction	1
Statement	2
Argument	9
Conclusion	14
Appendix	1a

TABLE OF AUTHORITIES

Cases:

Bowen v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986)	11, 12
Heckler v. *Ringer*, 466 U.S. 602 (1984)	9, 10, 11, 13
McNary v. *Haitian Refugee Center, Inc.*, 111 S. Ct. 888 (1991)	12
National Kidney Patients Ass'n v. *Sullivan*, No. 91-5073 (D.C. Cir. Mar. 13, 1992)	12
Norton v. *Mathews*, 427 U.S. 524 (1976)	13
Weinberger v. *Salfi*, 422 U.S. 749 (1975)	10, 11

Statutes and regulations:

Act of Oct. 21, 1986, Pub. L. No. 99-509, § 9341, 100 Stat. 2037	12
All Writ Act, 28 U.S.C. 1651	7
Medicare Act, 42 U.S.C. 1395 *et seq.*	2
42 U.S.C. 1395c-1395i	2
42 U.S.C. 1395f(b)(1)	2
42 U.S.C. 1395ff(b)(1)	12
42 U.S.C. 1395h(a)	3
42 U.S.C. 1395ii	5, 9
42 U.S.C. 1395j-1395w	2
42 U.S.C. 1395oo	7, 13
42 U.S.C. 1395oo(a)	3
42 U.S.C. 1395oo(d)	3
42 U.S.C. 1395oo(f)	3, 4, 10
42 U.S.C. 1395ww(d)	2

Statutes and regulations—Continued: Page

28 U.S.C. 1331 ..... 7, 9, 11
28 U.S.C. 1346 9
28 U.S.C. 1361 ..... 7, 8, 12
42 U.S.C. 405 (h) 5, 7, 9, 10, 12
42 C.F.R.:
Section 405.1803 3
Section 405.1829 (a) 3
Section 405.1875 4
Section 413.5 (c) (8) 2
Section 413.24 (f) 3
Section 413.102 (c) (2) 2, 13

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-6a) is unpublished, but the decision is noted at 952 F.2d 397 (Table). The opinion of the district court (Pet. App. 8a-19a) is reported at 754 F. Supp. 1097.

JURISDICTION

The judgment of the court of appeals was entered on December 23, 1991. The petition for a writ of certiorari was filed on March 21, 1992. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. The Medicare program, 42 U.S.C. 1395 *et seq.*, provides for payment of medical expenses for eligible aged and disabled persons. Part A of the Medicare program (Hospital Insurance Benefits) authorizes payments for primary institutional care to providers of services, including hospitals, skilled nursing facilities, and home health care organizations. See 42 U.S.C. 1395c-1395i. Part B of the Medicare program (Supplementary Medical Insurance Benefits) authorizes payments for physicians and other non-hospital services. See 42 U.S.C. 1395j-1395w. This case concerns a claim for reimbursement for home health care services under Part A.

a. Under Part A, the government reimburses providers for the services they furnish to beneficiaries. The provider receives either the "reasonable cost" or its "customary charge" for the services, whichever is less. 42 U.S.C. 1395f(b)(1).[1] A provider also receives a reasonable allowance for the services of its executives, including the owner of the enterprise, "providing their services are actually performed in a necessary function." 42 C.F.R. 413.5(c)(8). Reasonableness of executive compensation "may be determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable institutions; or it may be determined by other appropriate means." 42 C.F.R. 413.102(c)(2).

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[1] Most Part A Medicare claims for hospital inpatient services are reimbursed in accordance with prospectively determined rates under the new Prospective Payment System (PPS). See 42 U.S.C. 1395ww(d). That system does not apply to claims for reimbursement for home health care services.

b. To handle the vast number of claims for payment under the Medicare program each year, Congress authorized the Secretary of Health and Human Services to contract with "fiscal intermediar[ies]," primarily insurance companies, to process providers' claims. 42 U.S.C. 1395h(a). At the end of each fiscal year, a provider submits to its fiscal intermediary a cost report for Medicare services rendered during the year. 42 C.F.R. 413.24(f). The fiscal intermediary reviews the cost report and furnishes the provider with a "Notice of Program Reimbursement" setting forth the total amount of reimbursement to which the intermediary believes the provider is entitled. 42 C.F.R. 405.1803. In making its determination, the intermediary must comply with the provisions of the Medicare Act, the Secretary's regulations, and rulings and instructions issued by the Health Care Financing Administration (HCFA) in the Department of Health and Human Services. 42 C.F.R. 405.1829(a).

If the provider disagrees with the intermediary's determination, and the amount in controversy is $10,000 or more, the provider may appeal to the Provider Reimbursement Review Board (Board). 42 U.S.C. 1395oo(a). The Board has authority to "affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination." 42 U.S.C. 1395oo(d). The Secretary has discretion to review the Board's decision within 60 days. 42 U.S.C. 1395oo(f). The Secretary has delegated his authority to review the Board's

decisions to the Administrator of HCFA. 42 C.F.R. 405.1875.

The provider may obtain judicial review of any final decision of the Board or the Administrator of HCFA by filing a civil action within 60 days. 42 U.S.C. 1395oo(f). The provider also may seek judicial review of "any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy" if the Board determines that it is without jurisdiction to decide the issue. Such an action must be filed within 60 days of the Board's notification that it is without jurisdiction. *Ibid.*

In addition, a provider may request an "expedited judicial review" (EJR) hearing to obtain a formal determination by the Board of its authority to decide questions of law relevant to the controversy. 42 U.S.C. 1395oo(f). A provider who requests an EJR hearing is responsible for submitting supporting documents and materials necessary for the Board to review the situation, after which the Board must determine within 30 days whether it has authority to decide the relevant questions. If the Board fails to decide within 30 days, the provider may seek judicial review. *Ibid.*

The administrative and judicial review provisions of the Medicare Act provide the exclusive means of obtaining review of decisions of the Board. The statute provides:

> The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No

> action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

42 U.S.C. 405(h) (incorporated into the Medicare Act by 42 U.S.C. 1395ii).

2. a. Petitioner Total Care, Inc., provides home health care services to patients in North Carolina and South Carolina. Respondents Blue Cross and Blue Shield Association and Blue Cross and Blue Shield of South Carolina (Blue Cross) act as fiscal intermediaries to providers such as petitioner.

Petitioner filed a cost report for the period ending December 31, 1987, with Blue Cross. Blue Cross initially approved all of petitioner's claimed executive compensation and reimbursed petitioner for those expenses. After the cost report was audited, however, Blue Cross issued a Notice of Program Reimbursement reducing the amount of executive compensation for 1987 by approximately $30,000. In arriving at this reduction, Blue Cross used the "Tennessee Point System." Under that system, the intermediary assigns points based on the executive's education, experience, and hours worked, and makes adjustments based on the number of home health care "visits" performed by the provider. Pet. App. 11a.

On October 16, 1989, petitioner requested an EJR hearing from the Board on the executive compensation issue. On February 21, 1990, at the Board's request, petitioner submitted additional documentation in support of its application for an expedited hearing. Pet. App. 11a.

b. Two months later—before the Board determined whether it had jurisdiction to consider petitioner's

EJR request—petitioner filed this action in district court against the Secretary, HCFA officials, and Blue Cross. Petitioner's complaint alleged that the Secretary's failure to issue proper guidance to fiscal intermediaries on the methods to be used to calculate reasonable compensation to home health care executives had caused petitioner to receive a reduced amount of Medicare reimbursement. In particular, petitioner alleged that the "Tennessee Point System" applied by Blue Cross is invalid as applied to home health care owners and that the system has been applied "selectively and therefore arbitrarily." Compl. ¶¶ 56-61. Petitioner alleged that Blue Cross had improperly reduced its reimbursement on the basis of this erroneous methodology on its cost report for fiscal year 1987, and on its Periodic Interim Payment (PIP) Reports for 1988 and 1989. *Id.* ¶ 65.

Petitioner sought an injunction preventing the defendants from reducing future Medicare reimbursements for executive compensation, and from retaining funds they have recouped, until "statistically valid guidelines for home health executive compensation" are issued. Compl. ¶ A. In addition, petitioner asked the court to "invoke its mandamus power" to direct the defendants to issue valid compensation guidelines and to "satisfy the Court that [respondents] properly applied those guidelines to [petitioner's] claimed executive compensation prior to being permitted to retain monies they have already recouped or withholding or reducing future monies." *Id.* ¶ C.

c. About three weeks after petitioner filed its complaint, the Board conducted a hearing on petitioner's EJR request and denied petitioner's request for expedited judicial review. The Board found that there were "[q]uestions of fact to be decided, and that the

central issue does not concern the validity of a law, regulation or HCFA ruling but whether a regulation was properly implemented." Pet. App. 11a.

3. The district court dismissed petitioner's action for lack of jurisdiction. The court rejected petitioner's claim that it had jurisdiction under 28 U.S.C. 1331, explaining that the Medicare Act, by incorporating 42 U.S.C. 405(h), expressly precludes an action under Section 1331 to recover on any Medicare claim. The court also found that petitioner's attempt to characterize this action as one "to enforce procedural regularities" was "suspect" in light of the allegations in the complaint. Pet. App. 13a-14a. In addition, the district court rejected petitioner's argument that it had jurisdiction to issue a writ of mandamus under 28 U.S.C. 1361. The court explained that, even if it had jurisdiction under the mandamus statute, it "would not issue a writ of mandamus in this case" because petitioner had failed to exhaust its administrative remedies. *Id.* at 15a-16a.[2]

4. The court of appeals affirmed the dismissal of petitioner's action in an unpublished opinion. Pet. App. 1a-6a. It agreed with the district court that 42 U.S.C. 405(h) precludes jurisdiction under 28 U.S.C. 1331. "By initiating this suit before the [Board] had heard or decided its EJR request," the court concluded, petitioner "failed to comply with the full procedures for administrative and judicial review under the Medicare Act." Pet. App. 5a. In addition, the court of appeals agreed with the district

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[2] The district court also rejected petitioner's arguments that it had jurisdiction under the All Writs Act, 28 U.S.C. 1651, and the expedited judicial review provision of the Medicare Act, 42 U.S.C. 1395oo. Pet. App. 16a-18a. Petitioner did not pursue those arguments in the court of appeals.

court "that [petitioner's] attempt to characterize this as an action to 'enforce procedural regularities' is suspect because [petitioner] continues to dispute its reimbursements for 1987, 1988, and 1989." *Ibid.* The court of appeals also rejected petitioner's claim of jurisdiction under 28 U.S.C. 1361. The court noted that mandamus jurisdiction is precluded under the Medicare Act where the plaintiff has failed to exhaust administrative remedies. Thus, the court of appeals concluded that "mandamus jurisdiction, even if available, would be inappropriate" in this case "in light of [petitioner's] failure to exhaust available avenues of relief." Pet. App. 6a.

5. While the case was pending in the court of appeals, the Board issued a decision granting petitioner's claim for executive compensation for 1987. The Board found that "the $86,322 compensation paid by the Provider to its owner/administrator is reasonable," and expressly rejected the methodology upon which Blue Cross relied. App., *infra*, 13a. The Board emphasized that the methodology for determining executive compensation must take into account salary amounts paid by comparable institutions, as well as market forces that determine salaries. *Id.* at 14a. The Administrator of HCFA declined to review the Board's decision. *Id.* at 17a.

ARGUMENT

The court of appeals correctly held that jurisdiction over petitioner's claims is precluded. Even if the district court had jurisdiction to issue a writ of mandamus, mandamus was not warranted in this case because petitioner failed to exhaust its administrative remedies. Furthermore, petitioner has now prevailed before the Board on its 1987 claim. Further review therefore is plainly unwarranted.

1. a. The district court lacked jurisdiction to consider petitioner's claims under 28 U.S.C. 1331. The Medicare statute expressly provides that "[n]o findings of fact or decision of the secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter." 42 U.S.C. 405(h) (incorporated into the Medicare Act by 42 U.S.C. 1395ii).

In *Heckler* v. *Ringer*, 466 U.S. 602 (1984), the Court held that 42 U.S.C. 405(h) bars the district court from asserting federal question jurisdiction over actions relating to claims under Part A of the Medicare Act. Under *Ringer*, a district court may assert jurisdiction over Part A reimbursement claims and legal issues that bear on those claims only *after* the plaintiff has exhausted the Medicare Act's administrative process. 466 U.S. at 627.

Petitioner cannot bypass the exhaustion requirement simply by framing a "constitutional" claim. Section 405(h) applies to "any 'action' seeking 'to recover on any [Social Security] claim'—irrespective of whether resort to judicial processes is necessitated by discretionary decisions of the Secretary or by his

non-discretionary application of allegedly unconstitutional statutory restrictions." *Weinberger* v. *Salfi*, 422 U.S. 749, 762 (1975). While Section 405(h) does not preclude constitutional claims, it "require[s] that they be brought under jurisdictional grants contained in the Act, and thus in conformity with the same standards which are applicable to nonconstitutional claims arising under the Act." *Ibid.*

Nor can petitioner bypass Section 405(h) by labelling its claims as "procedural" in nature. Both the district court (Pet. App. 13a-14a) and the court of appeals (*id.* at 5a) found that petitioner's attempt to characterize this action as procedural was suspect at best. In any event, this Court made clear in *Ringer* that exhaustion is required even if a party raises "procedural" objections or seeks declaratory relief to resolve those objections. 466 U.S. at 614-615. All such objections must "be channeled first into the administrative process which Congress has provided." *Id.* at 614.

b. Petitioner's contention (Pet. 20-23) that the Board's jurisdiction is limited, and that therefore petitioner will have no opportunity to obtain judicial review of its claims, is meritless. As this Court recognized in *Salfi*, Section 405(h) does not preclude judicial review of constitutional claims, but merely requires that petitioner first go through the administrative process. See 422 U.S. at 762. Nothing in the Medicare Act precludes petitioner from raising its constitutional claim after exhausting its administrative remedies. Indeed, the Medicare Act expressly provides that courts may consider legal issues not within the purview of the Board. See 42 U.S.C. 1395oo(f).

Petitioner's suggestion that exhaustion would serve no purpose in light of the Board's allegedly limited

jurisdiction is also incorrect. Exhaustion prevents "premature interference with agency processes," allows the agency to apply its expertise and correct its errors, and gives the agency a chance "to compile a record which is adequate for judicial review." *Salfi*, 422 U.S. at 765; see also *Ringer*, 466 U.S. at 619 n.12. In addition, exhaustion may obviate the need for judicial review, since the agency may award or deny the claimant relief on independent grounds. See *Salfi*, 422 U.S. at 762.

This case, like *Ringer* itself, "aptly demonstrates the wisdom of Congress' exhaustion scheme." *Ringer*, 466 U.S. at 619 n.12. The administrative proceedings resulted in the compilation of an administrative record that shed light on the various methods for determining whether executive compensation is reasonable. In addition, the administrative proceedings afforded the Board an opportunity to state its view as to how the statute and implementing regulations and directives should be applied. And in the end, petitioner *prevailed* in the administrative process on its claim for 1987. In accepting petitioner's claim, the Board expressly rejected the method proffered by Blue Cross for determining such compensation. See App., *infra*, 13a-14a.

c. Petitioner's suggestion (Pet. 20-22) that *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), establishes federal question jurisdiction for Medicare Part A claims is completely mistaken. In *Michigan Academy*, the Court held that a party challenging the Secretary's methods and procedures relating to Medicare *Part B* claims could seek judicial review under 28 U.S.C. 1331. See 476 U.S. at 678-681. At the time the Court decided *Michigan Academy*, the Medicare Act provided no mechanism for judicial review of Part B reimbursement claims. As a result, the Court declined to find that general

federal question jurisdiction was entirely precluded by 42 U.S.C. 405(h), because to do so would have precluded all judicial review of legal issues—including constitutional issues—that may affect Part B claims. See 476 U.S. at 680; see also *McNary* v. *Haitian Refugee Center, Inc.*, 111 S. Ct. 888, 899 (1991) ("Inherent in our analysis [in *Michigan Academy*] was the concern that absent such a construction of the [judicial] review provisions of the Medicare statute, there would be 'no judicial review at all of substantial statutory and constitutional challenges to the Secretary's administration of Part B of the Medicare program.' ") (quoting *Michigan Academy*, 476 U.S. at 680). This case concerns *Part A* of the Medicare statute, not Part B. Because the Medicare Act provides a comprehensive scheme for judicial review of provider claims under Part A, see 42 U.S.C. 1395oo, the rationale of *Michigan Academy* does not apply to this case.[3]

2. Petitioner's contention that the district court had jurisdiction under the mandamus statute, 28 U.S.C. 1361, likewise merits no further review. This Court has declined to decide whether 42 U.S.C. 405(h) altogether precludes mandamus jurisdiction in cases in which mandamus jurisdiction would have been inappropriate in any event. See, *e.g.*, *Ringer*,

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[3] Four months after *Michigan Academy* was decided, Congress amended the Medicare Act to extend the administrative and judicial review procedures that are available to beneficiaries under Part A or Part B claims. See Act of Oct. 21, 1986, Pub.L.No.99-509, § 9341, 100 Stat. 2037. As amended, 42 U.S.C. 1395ff(b)(1) provides that a claimant may seek judicial review of "the amount of benefits under part A *or part B* of this subchapter." (emphasis supplied). As a result, the rationale of *Michigan Academy* no longer applies even under Part B. See *National Kidney Patients Ass'n* v. *Sullivan*, No. 91-5073 (D.C. Cir. Mar. 13, 1992), slip op. 11-14.

466 U.S. at 616; *Norton* v. *Mathews*, 427 U.S. 524, 528-533 (1976). This is such a case.

Mandamus is an extraordinary remedy that is available to a plaintiff "only if he has exhausted all other avenues of relief and only if the defendant owes him a clear nondiscretionary duty." *Ringer*, 466 U.S. at 616. As both courts below concluded, mandamus would be inappropriate in this case even if it were available, because petitioner failed to exhaust its administrative remedies.[4]

Petitioner incorrectly asserts (Pet. 17) that no alternative remedy is available because of the "restrictions" on administrative and judicial review under 42 U.S.C. 1395oo. The Board concluded that it had jurisdiction to consider petitioner's claim, see Pet. App. 11a, and in fact awarded petitioner complete relief for fiscal year 1987. But even if the Board had concluded that it lacked jurisdiction to decide petitioner's claims, petitioner could have obtained a judicial determination of those claims. Under 42 U.S.C. 1395oo, the court may review "a question of law or regulations relevant to the matters in controversy" that is beyond the jurisdiction of the Board. As a result, petitioner can obtain judicial review of its legal objections to the manner in which a fiscal intermediary resolved an executive compensation issue, simply by exercising its right to judicial review under 42 U.S.C. 1395oo after the Board renders its decision.

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[4] In addition, mandamus would be inappropriate because the Secretary does not owe the petitioner a clear, nondiscretionary duty to promulgate additional guidelines. The applicable regulation allows a fiscal intermediary to use "any appropriate means" to determine executive compensation. 42 C.F.R. 413.102(c)(2).

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted..

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MAY 1992

APPENDIX

PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION 91-D65

Case No. 90-0078

PROVIDER—TOTAL CARE, INC.
CHARLOTTE, NORTH CAROLINA

PROVIDER NO. 34-7091

VS.

INTERMEDIARY—BLUE CROSS AND BLUE SHIELD ASSOCIATION/BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA

Date of Hearing—January 3 and 4, 1991

Cost Reporting Period Ended—December 31, 1987

ISSUES:

1. Whether the Intermediary's adjustment disallowing a portion of the owner's compensation is correct.

2. Whether the Intermediary's adjustment limiting the dues paid by the Provider to the costs of Homecare Alliance, an alleged related party, is correct. (On-the-Record)

SUMMARY OF FACTS:

The Provider is a home health agency (HHA) located in Charlotte, North Carolina. In the fiscal year ending December 31, 1987, it had home care visits totalling 69,098. The Intermediary furnished the Provider with a Notice of Program Reimbursement which questioned the above-claimed costs. The Provider filed a request for hearing to the Provider Reimbursement Review Board (Board) appealing the Intermediary's determination under the provisions of 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of those regulations.

Issue 1—Owner's Compensation

The chief operating officer, the owner of the Provider, received $86,322 of compensation in 1987 consisting of $87,583 of salary, $2061 of shared management services, and $800 of director's fees. The Intermediary evaluated that compensation using a guideline known as the "Tennessee Point System." The "Tennessee Point System" is based on HHA services performed, and uses a combination point/visit method developed by Blue Cross and Blue Shield of Tennessee. The Health Care Financing Administration's (HCFA's) Atlanta Regional Office performed a sal-

ary survey of 94 HHAs in 1975 that was used to develop the Tennessee Point System. The 1975 data base salary ranges were updated for inflation using factors developed by HCFA. Applying the survey results to the Provider's owner compensation resulted in $57,308 in allowable compensation. That limitation reduced Medicare reimbursement by approximately $25,000.

Provider's Contentions:

The Provider contends that the Intermediary's adjustments to the Provider's claimed owner's compensation in 1987 are unreasonable and unlawful. The adjustments were not made by comparing compensation paid for comparable services and responsibilities in comparable institutions. The Intermediary completely ignored the most comparable compensation and institution available—the Provider. In 1984 and 1985, the Blue Cross and Blue Shield Association (BCBSA) reversed Blue Cross and Blue Shield of North Carolina's adjustment to owner's compensation and allowed owner's compensation in full. In 1986, the Intermediary made no adjustment to the Provider's claimed compensation. Thus, it allowed full compensation of $67,649, $69,398 and $70,632 for 1984-1986, respectively. The Intermediary ignores the fact that it and other intermediaries allowed similar or higher salaries for other HHA owners at comparable institutions. The Provider's visits increased by 9% from 1983 to 1987, while its revenue increased by $331,273 or 12%. Despite this, the Intermediary's adjustment to the 1987 salary placed it $10,341 less than what BCBSA allowed in 1984. Taking the 1984 salary allowed by BCBSA and multiplying it by the Consumer Price Index yields a reasonable salary of

$89,386 for 1987. Increasing the 1984 BCBSA allowed salary by the nationally-recognized Hay Management Consultants (Hay) index of 6.6% (annual salary increase) results in a reasonable salary level of at least $81,947.

The Intermediary has not compared the owner's compensation with other comparable institutions using the "other appropriate means" regulatory requirement in 42 C.F.R. § 413.102(c)(2). Because HCFA has not approved the use of "other appropriate means," BCBSA and its subcontractor plans have failed to explain where they obtained the authority to use the "Tennessee Point System" or any other method to adjust the Provider's cost report. The Intermediary has failed to produce any data to support the "Tennessee Point System." Moreover, the Intermediary's reliance on the "Dunham II" study, another point/compensation evaluation system, to arrive at an alternative compensation for the owner's compensation constitutes an unlawful reopening of the cost report. Its use of that study, which was developed in 1990, to support its 1989 adjustment of the 1987 cost report constitutes unlawful retroactive rulemaking. Finally, the Intermediary failed in its responsibility as a regional home health intermediary to develop uniform cost and performance criteria.

The Provider's claimed owner's compensation in 1987 was reasonable and not substantially out-of-line. The amount of compensation paid in 1987 is reasonable as supported by another study, the "Dunham I" study. In 1984, Dr. Dunham completed a study of many of the positions of employment at Total Care, including the owner's position, president/chief executive officer. This study, "Dunham I", was based on a

methodology involving the use of the Professional and Managerial Position Questionnaire (PMPQ) to identify comparable responsibility levels in HHA jobs and hospital jobs so that compensation levels for HHA jobs could be developed based on the actual salaries paid for comparable hospital jobs. The Provider's owner completed the PMPQ on her own which resulted in a total of 2525 PMPQ points in 1984. Dr. Dunham extrapolated that result to correspond with a pay range of $46,082 to $76,804. To determine the appropriate 1987 pay range, the 1984 range was trended forward by 6.6% per year, the inflation factor recommended by the Wyatt Company which developed the underlying hospital data used in "Dunham I". T-1, pp. 90-91. Utilizing that inflation factor yields a recommended pay range of $54,884 to $91,475 for 1987. Given the owner's actual salary in 1987 was $86,322, Dr. Dunham concluded that her 1987 salary was reasonable. T-1, p.96.

The amount of compensation paid in 1987 is reasonable as supported by the "Dunham II" study. The "Dunham II" methodology was based on essentially the same procedures as "Dunham I", but used 1990 hospital salary data. It differed from the earlier study, however, in that it involved the development of a regression equation to relate PMPQ points to hospital salaries. The Provider participated in the "Dunham II" study, and its owner received a score of 2830 points on her PMPQ. Based on this score, Dr. Dunham recommended a 1990 salary range of $68,054 to $105,082. Using Dr. Dunham's suggested deflation factor of .781, the appropriate salary pay range for 1987 was $53,150 to $82,069. Despite Dr. Dunham's expert opinion on the proper use of the pay ranges that he developed, the Intermediary focused solely on

the midpoint of the 1990 range ($86,068), and trended it backward to impose a 1987 midpoint salary cap of $66,438.

The amount of compensation paid in 1987 is also reasonable as supported by Hay. Hay provides compensation consulting to BCBSA and approximately twenty-eight Blue Cross plans in the United States. T-1, p.212, and T-2, p.42. In 1985, the Provider commissioned Hay to review its pay structure. Based on the Hay Chart Guide Profile Method of Job Evaluation, which focuses on the know-how, problem-solving and accountability dimensions of a particular job and based upon a database of thousands of companies, Hay originally recommended a 1985 salary range for the owner between $50,000 and $75,900. T-1, p.236. On the Provider's 1985 cost report, it claimed $69,398 of owner's compensation which the Intermediary allowed. For 1987, the Hay salary range was $69,248 to $103,480. On the cost report, the Provider claimed $86,322 in compensation, well within the Hay range.

The amount of compensation paid in 1987 is reasonable when compared with salaries paid by other home health agencies in North Carolina. The regulations require the Intermediary to reimburse providers for a reasonable allowance of compensation provided the amount is not substantially out of line with other, similarly situated providers. Given that the owner's salary at the Provider was within range or less than the salaries claimed and allowed by owners of comparable HHAs in 1987, her salary was both reasonable and not substantially out-of-line.

During the hearing, the owner testified that she had personal knowledge that other HHA administrators earned more than she did. T-2, p.146. The independ-

ent accountant for the Provider confirmed in his testimony that Medicare has allowed significantly more for other agencies. T-2, p.222.

Intermediary's Contentions:

The Intermediary contends that 42 C.F.R. § 413.102 (c)(2) allows it to determine reasonable compensation by "other appropriate means". This method is supported by Provider Reimbursement Manual (PRM) § 902.3 which defines reasonable compensation as the fair market value of services rendered by an owner in connection with patient care. Fair market value is determined by supply and demand factors of the open market. There is no open market for positions like the Provider's owner/administrator. Therefore, "other appropriate means" of determining owner's compensation must be made. Since there are no data for comparable salaries set by open market forces, the Intermediary has not developed salary surveys of HHAs.

The "Dunham II" study used by the Intermediary as an alternative to the "Tennessee Point System" study is an adequate "other appropriate means" as stated in 42 C.F.R. § 413.102(c). In fact, the "Dunham II" study followed a methodology that the Provider appeared to sponsor. The Provider submitted the study within two weeks of the hearing. Since it thought that the study had sufficient probative value to enter it into the record, the Provider should not object to the Intermediary's modified adjustment which was based on that study. The study which compares HHA positions with hospital jobs of similar responsibility levels is the best tool available for intermediaries to use to measure the reasonableness of HHA compensa-

tion. Also, any errors in the study's premises are in the favor of HHA owners.

The study is a good basis for comparison because there are general open market conditions for hospital employees. Also, there are longstanding independent management consultant studies available to objectively measure hospital administrative positions. The Provider's witness indicated that there was no similar general study for HHA positions. T-1, pp.111-112. Hay, the party that helped establish the Provider's owner's compensation, used its own hospital database and some informational data from the National Association of Home Care. T-2, p.10. Hay did not have any home health agency database to work with. T-1, p.235. The fact that both Dunham and Hay had access to information on hospital salaries and no comparable information on HHA salaries, supports the Intermediary's position that there really was no open market for establishing HHA administrators' compensation levels. Moreover, the Board has considered methods such as the Dunham studies and comparisons to small hospitals as "other appropriate means" for determining the reasonableness of HHA owners' compensation.

The Intermediary does not agree with the Provider that its allowance of the owner's compensation in 1986 precludes it from making an adjustment on the 1987 compensation using either the "Tennessee Point System Method" or the "Dunham II" study. The original adjustment on 1987's compensation was reasonable. Using the 1989 Modern Healthcare Survey for hospitals with revenue of $7 to $20 million, and deflating its results to 1987 levels, results in a compensation of $60,300. That is comparable to the $58,308 established by the "Tennessee Point System."

The 1990 "Dunham II" study, deflated to 1987 dollars, produced a recommended salary of $66,438. This is a reasonable, alternative compensation.

The Hay study recommendation that the Provider used to establish its owner's compensation level is less reliable than the "Dunham II" study. The Hay study results in a midpoint compensation of $73,400 which is substantially above the "Dunham I" study and "Dunham II" study midpoints. The Hay analysis produced 1486 PMPQ points. Further, the actual chart used to develop the Provider's owner points is not in the record. T-2, p.8. The Hay study ignores job titles and has a premise that "points are points." Its universe of hospital positions to develop salaries was taken from a database of 21 hospitals under 500 beds. However, these hospitals were all Hay clients which tend to be larger hospitals. Therefore, the 21 hospitals in the database would probably be closer to 500 beds than 100 beds. T-2, p.39.

In reviewing the Dunham studies, the Board has expressed reservations about the comparability of HHAs to hospitals. However, Dr. Dunham at least did his analysis using widely published data from hospitals of all size ranges including smaller hospitals with revenue bases larger (but closer) to the Provider's than the hospitals Hay used.

Issue No. 2—Dues Paid to Alliance

In April 1987, five HHAs collectively formed Home Care Alliance of Southwest, Inc. (Alliance), a proprietary corporation, to provide its owners shared management, bulk purchasing, and group insurance coverage. Two blocks of stock were issued to the founding agencies. One block was issued to the

HHAs which had voting power. The other block was sold to the chief executive officer of each facility. At the inception of Alliance, the Provider had a 20% ownership. In November 1987, another provider joined the group. As a result, the Provider's percentage of ownership dropped from 20% to 16%. The Provider's owner also had a 5% ownership in Alliance's preferred stock.

The Provider claimed $3,500 of dues paid to Alliance as an allowable cost. The Intermediary considered the Provider and Alliance as related parties under 42 C.F.R. § 413.17, and allowed $2,146 of the dues. Its disallowance of $1,354 was the Provider's share of Alliance's total profit of $7,902 in 1987.

Provider's Contentions:

The Provider contends that this adjustment is erroneous. First, the stated basis for the adjustment is the related organization regulation although the Intermediary actually allocated profits to members of the Alliance to determine the amount of the adjustment. Second, the Intermediary has not shown that the Provider and Alliance are related by either common ownership or control as required in the related organization provisions of 42 C.F.R. § 413.17. Common Ownership means "significant ownership or equity interest" in the provider and in the supplying organization. Informally, HCFA and the Board have indicated that significant ownership means at least 20% ownership in the supplying organization. The Provider owned 20% of the common stock of the Alliance between April 10, 1987, and November 1987. However, the Provider's share of common stock ownership was 16.67% during November and December. The Provider's owner had but 5% of preferred stock while the remaining 95% was owned by people out-

side of the Provider. Since the Provider did not own over 20% of the Alliance in 1987, there is no common ownership under the related organization regulation.

Control means "the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization." 42 C.F.R. § 413.17(b)(3). The Provider's relationship with Alliance fails to satisfy the control rules and, therefore, the two organizations are not related. The Provider lacked the ability to control the actions or policies of Alliance since it controlled only between 16.67% and 20% of the common stock (the voting power) of the Alliance. However, the Provider's owner was not a director of Alliance in 1987. Moreover, the other shareholders of Alliance were the Provider's competitors, and the competitors owned 95% of the preferred stock. By definition, these facts would not allow the Provider or its owner the power to exercise significant influence or control over Alliance.

Intermediary's Contentions:

The Intermediary contends that the Provider and Alliance are related by common ownership and control in accord with 42 C.F.R. § 413.17. The element of common ownership is present in both the Provider and Alliance. Ms. Peggy Davis owns 100% of the stock of the Provider. The Provider's ownership in Alliance ranged from 16.67% to 20%. In addition, Ms. Davis personally owns stock in Alliance.

The element of control is present in both the Provider and Alliance. Ms. Davis is President and Chief Executive Officer of the Provider. The Provider stated that Ms. Davis was not an officer of Alliance and she

was not in a position to exercise control over it. This statement is in direct contradiction with information contained in the minutes of the Board of Directors of Alliance. According to those minutes, Ms. Davis was elected Vice-Chairman and Secretary of Alliance. In fact, she was the only person to hold two offices.

The Provider maintains that because internal HCFA pronouncements have indicated that stock ownership of less than 20% is not a "substantial ownership" as defined by PRM §§ 1000 and 1004, the Provider and Alliance are not related organizations. First, the Provider's ownership in Alliance was not less than 20% until the last two months of the year. Second, the Intermediary does not have copies of any HCFA pronouncement stating that stock ownership of less than 20% is not a "substantial ownership." However, the minutes from the Regional Home Health Intermediaries (RHHI) which was held in October 1989, indicated that a 10% of ownership is used by most RHHIs as a benchmark of "substantial" ownership.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

Law—Title XVIII, Social Security Act:

§ 1861(v)(1)(A) —Reasonable Cost

Regulations—42 C.F.R. § 405, Subpart D:

a) § 413.102(c) —Compensation of Owners

b) § 413.17(b)(1) —Related to the Provider

c) § 413.17(b)(2) —Common Ownership

d) § 413.17(b)(3) —Control

Program Instructions—Provider Reimbursement Manual (HIM 15-1):

a) § 902.3	—Reasonableness
b) § 1000	—Principle
c) § 1004	—Determination of Common Ownership Or Control

FINDINGS AND CONCLUSION:

The Board, after considering the facts, contentions of the parties, evidence submitted, and post-hearing briefs finds and concludes as follows:

Issue No. 1—Owner's Compensation

The Board finds that the $86,322 compensation paid by the Provider to its owner/administrator is reasonable based on Hay's January 1985 study of the Provider's administrative positions. The witness from Hay testified that the American Health Care Management Survey showed a compensation range of $50,591-$75,887, with a midpoint of $63,239. Trending those dollars forward to 1987, the year in dispute, results in a range of approximately $80,000 to $120,000, with a midpoint of approximately $88,000. The owner's compensation at the Provider falls within that range and is, therefore, reasonable.

The Board notes that the Dunham studies are based on the job responsibilities in HHAs and hospitals. It assumes that a job in an HHA should be paid at the same level as a job with similar responsibilities in a hospital. However, the author of the study testified that there is no statistical proof of the validity of that assumption. T-1, pp.190-191. The witness said

that his methodology assumed the validity of the principle of comparable worth. T-1, pp.191-192. More specifically, the PMPQ was predicated on the principle of comparable worth. T-1, p.192. Although there is no evidence of it in the record, the witness testified that the labor pools for hospitals and HHAs are comparable. Most significantly, the witness testified that *market factors were not included in his analysis.* T-1, p.194. Therefore, his methodology assumes that it is equally easy/difficult to recruit employees in hospitals and HHAs!

Regulation 42 C.F.R. § 413.102(b)(2) states that, "[r]easonableness requires that the compensation allowance—(i) Be such an amount as would ordinarily be paid for comparable services by *comparable* institutions" (emphasis added). The methodology employed by Dr. Dunham does not take into account salary amounts paid by comparable institutions. By referring to comparable services in comparable institutions, the regulation must include the market forces that determine salaries. In ignoring market factors, Dr. Dunham's methodology does not comply with the requirements of the regulation.

Also, the principle of comparable worth, on which the validity of the PMPQ is predicated, does not include variations arising from demand and supply in the marketplace. In relying on the validity of the principle of comparable worth, the study by Dr. Dunham again does not comply with the requirements of the regulation.

Issue No. 2—Dues Paid to Alliance

The dues paid by the Provider to Alliance are payments made between related parties as defined in 42 C.F.R. § 413.17. The Provider is related to the group purchasing company through ownership. Its 16-⅔% to 20% ownership in this company during the year in dispute meets the regulatory definition of common ownership, 42 C.F.R. § 413.17(b)(2). Moreover, the Provider exercises control over the group purchasing company as defined in 42 C.F.R. § 413.17(b)(3). The Provider and its owner had the power to directly and significantly influence the actions and policies of the organization. The owner's position of Vice-Chairperson and Secretary of the Alliance clearly demonstrates that she had the power to significantly influence its policies. Allowable costs are, therefore, limited to only the costs incurred by Alliance.

DECISION:

Issue No. 1—Owner's Compensation

The $86,322 of compensation paid to the owner of the Provider is reasonable. The Intermediary's adjustment is reversed.

Issue No. 2—Dues Paid to Alliance

Alliance and the Provider are related parties. Allowable costs are limited to the costs incurred by the group purchasing company. The Intermediary's adjustment is affirmed.

Board Members Participating:

Keith E. Braganza
Sally A. Kirkpatrick
Joseph F. Sloan

FOR THE BOARD:

Aug. 22, 1991

/s/ Jack Martin
JACK MARTIN
Chairman

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Office of Attorney Advisor
6325 Security Boulevard
Baltimore, Maryland 21207

Oct. 10, 1991

Charles F. MacKelvie, Esquire
Hinshaw, Culbertson, Moelmann, Hoban and Fuller
222 North LaSalle Street
Suite 300
Chicago, Illinois 60601-1081

Dear Mr. MacKelvie:

Re: *Total Care, Inc.*, PRRB Case No. 91-D65 (08/22/91) (FYE 12/31/87)

This is to advise that the Administrator of the Health Care Financing Administration has declined to review the decision entered by the Provider Reimbursement Review Board in the captioned case.

If the Provider wishes to obtain judicial review of the matter, civil action must be initiated within 60 days of the date the Board's decision was received in accordance with 42 CFR 405.1877.

Sincerely yours,

/s/ Marion T. Silva
MARION T. SILVA
Attorney Advisor

Enclosure

cc: Bernard M. Talbert, Esquire, Intermediary's Headquarters

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No. 91-1534

Supreme Court, U.S.
FILED
JUN 8 1992
OFFICE OF THE CLERK

In The Supreme Court of the United States October Term, 1991

TOTAL CARE, INC.,

Petitioner,

v.

LOUIS SULLIVAN, Secretary of the United States Department of Health and Human Services; GAIL WILENSKY, Administrator of the Health Care Financing Administration; GEORGE R. HOLLAND, Regional Administrator of Region IV of the Health Care Financing Administration; JAMES C. HOLLOWAY, Executive Director, Department of Operations for Federal Programs of BLUE CROSS AND BLUE SHIELD ASSOCIATION; and BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA,

Respondents.

PETITIONER'S RESPONSE TO FEDERAL RESPONDENTS' BRIEF IN OPPOSITION

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TABLE OF CONTENTS

Page

Table of Authorities.....ii

I. Introduction.....1

II. The Medicare Act Restricts The Scope Of Judicial Review On Appeal From The PRRB So As To Preclude Total Care From Presenting Its Present Claims Through The Administrative Forum.....1

III. The Present Ad Hoc System For Reimbursing Owners'/Executives' Compensation Completely Ignores Applicable Medicare Regulations And General Instructions.....2

IV. By Prohibiting Jurisdiction In This Case, The Court Will Create Far-Reaching Implications For All Regulated Parties And Administrative Agencies In The United States.....4

V. Respondents' Arguments That §405(h) Precludes Jurisdiction In This Case Are In Error.....5

A. The Circuit Courts Of Appeals Are Divided On The Issue Of Jurisdiction In Light Of §405(h) Because Of The Important Constitutional Questions Raised.....6

B. Nothing Can Be Gained By Dismissing This Case Back To The Administrative System.....8

C. Total Care's Complaint Does Not Involve A "Claim" Under The Medicare Act Subject To Redress Through The Administrative Procedure.....9

V. Conclusion.....10

TABLE OF AUTHORITIES

Cases: **Page**

Alexander's Home Health Agency, PRRB Hearing Dec. No. 88-D30 (September 2, 1988).....3

American Hospital Association v. Sullivan, et. al., No. 88-2027 (D.D.C. 1990).....7,8

Americare Home Health Agency v. Sullivan, et. al., No. 90-2950-HB (D.Tenn. 1992).....9

Bellantoni v. Schweiker, 566 F.Supp. 313 (E.D.N.Y. 1983).....8

Belles v. Schweiker, 720 F.2d 509 (8th Cir. 1983).....8

Beverly Hospital v. Bowen, No. 88-5011 (D.C.Cir. 1988).....6,7

Burlington Memorial Hospital, 644 F.Supp. 1020 (W.D.Wis. 1986).....7

City of New York v. Heckler, 742 F.2d 729 (2d Cir. 1984), aff'd, Bowen v. New York, 476 U.S. 467 (1986).....8

College of American Pathologists v. Heckler, 734 F.2d 859 (D.C.Cir. 1984).....7

Comprehensive Home Health Care I., Inc. v. Sullivan, et. al., No. 99-9-CIV-7 (E.D.N.C. 1990).....3

Dietsch v. Schweiker, 700 F.2d 865 (2d Cir. 1983).....8

Dixon v. Quern, 537 F.Supp. 990
(N.D.Ill. 1982).....8

Elk Valley Professional Affiliates, Inc. v. Sullivan,
No. 4- 90-198 (E.D. Tenn. 1991).....9

Ellis v. Blum, 643 F.2d 68 (2d Cir. 1981).....8

Heckler v. Ringer, 466 U.S. 602 (1984).....6

Hennings v. Heckler, 601 F. Supp. 919
(N.D. Ill. 1985).....8

Lopez v. Heckler, 725 F.2d 1489 (9th Cir. 1984)
vacated and remanded on other grounds,
469 U.S. 1082 (1984).....8

Memorial Hospital v. Sullivan, No. 91-727
(D.C.Cir. 1991).....7

Mental Health Association of Minnesota v. Heckler,
720 F.2d 965 (8th Cir. 1983).....8

McCuin v. Secretary, 817 F.2d 161
(1st Cir. 1987).....4

National Association of Home Health Agencies v.
Schweiker, 690 F.2d 932 (D.C. Cir. 1982),
cert. denied, 459 U.S. 1205 (1983).....7

Samaritan Health Center v. Heckler,
636 F.Supp. 503 (D.D.C. 1985).....8

Silvis v. Heckler, 578 F.Supp. 1401
(W.D.Pa. 1984).....8

Sinatra v. Heckler, 566 F.Supp.
1354 (E.D.N.Y. 1983).....8

Total Care, Inc. v. Sullivan, No. 91-1514
(4th Cir. 1991).....5

Statutes and Rules:

5 U.S.C. §706....,.....1
28 U.S.C. §1331.....7,10
42 U.S.C. §405(h).....5,6,8,9
42 U.S.C. §1395oo.....1,6,8
42 U.S.C. §1395oo(f).....1,2
42 C.F.R. §405.1869.....1
42 C.F.R. §405.1875.....1
42 C.F.R. §413.102.....2

Other:

Medicare HIM-15 Chapter 9.....2

PETITIONER'S RESPONSE TO FEDERAL RESPONDENTS' BRIEF IN OPPOSITION

I. Introduction

At issue is whether Congress can prevent the courts from exercising Mandamus and/or Federal Question jurisdiction over a Medicare provider's complaint without current exhaustion of administrative remedies where no other forum for relief is provided through the administrative system. This Petitioner has previously exhausted its administrative remedies for the same issue three times.

II. The Medicare Act Restricts The Scope Of Judicial Review On Appeal From The PRRB So As To Preclude Total Care From Presenting Its Present Claims Through The Administrative Forum

Usually, in cases involving Medicare cost report disputes, a provider is required by 42 U.S.C. §1395oo to present its claims to the Provider Reimbursement Review Board ("PRRB" or "Board"), located in Baltimore, Maryland, (provided the jurisdictional amount in controversy is met) before appealing to the court system. The PRRB is only empowered, however, to affirm, reverse, or modify a determination of reimbursement made by the Intermediary and to make other modifications to "matters covered by" the particular fiscal year cost report. 42 C.F.R. §405.1869. The Administrator of the Health Care Financing Administration ("HCFA") then has authority to review the Board's decision. 42 C.F.R. §405.1875. A provider dissatisfied with the Board's or Administrator's decision is entitled to seek judicial review. 42 U.S.C. §1395oo.

The Medicare Act expressly states, however, that the provider's action in court on review from the Administrator's or Board's decision shall be governed by the applicable provisions of chapter 7 of title 5 of the United States Code - the Administrative Procedures Act ("APA"). 42 U.S.C. §1395oo(f). The APA, in turn, limits the court to a consideration of whether the PRRB or Administrator acted arbitrarily or capriciously, with abuse of discretion, not in accordance with the law, or unsupported by substantial evidence. 5 U.S.C. §706.

Respondents' assertion that "the Medicare Act expressly provides that courts may consider legal issues not within the purview of the Board" under §1395oo(f) is simply wrong and contradicts the express language of the Medicare statute.

III. The Present Ad Hoc System For Reimbursing Owner's Compensation Completely Ignores Applicable Medicare Regulations And General Instructions

Medicare regulations issued in 1966 require the Secretary of the U.S. Department of Health and Human Services ("Secretary") to pay "a reasonable allowance" for compensation of owners/executives of Medicare providers:

determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable institutions, . . .[or by] other appropriate means.
42 C.F.R. §413.102.

To effectuate this provision, the Secretary published general instructions to the Intermediary and its subcontractors in 1969 which required them to conduct surveys of compensation paid in comparable institutions and consolidate the survey results into ranges for determining reasonable compensation. The Secretary has never issued any instructions as to what constitutes "other appropriate means" under the regulation. Despite these general instructions, no surveys have been conducted since 1974, and no valid ranges for determining reasonable compensation currently exist. Medicare HIM-15 Chapter 9.

As a result, there is presently a patchwork, ad hoc system for determining reasonable Home Health Agency ("HHA") owners'/executives' compensation which is unfair to providers. This system (which is really not a system at all) offers no advance warning to providers as to what the rules will be to make compensation adjustments; moreover, the system often yields adjustments which the Intermediary cannot subsequently support in the face of a provider's challenge.

Some of the various methodologies used by local intermediaries to adjust home health executives' compensation include:

- The so-called "Michigan survey"
- Ranges of compensation derived from 1964 skilled nursing facility data
- The Independence Blue Cross regression analysis
- The Region V survey of rehabilitation agencies
- The Tennessee Point System
- The Alabama Visit Method
- The Consumer Price Index Method
- The Dunham Study
- The Hay & Associates methodology

Although each of these methodologies is derived from some limited sort of regional compensation data, local intermediaries in other regions of the country often utilize them without modification. For example, Blue Cross and Blue Shield of North Carolina recently utilized the Independence Blue Cross regression analysis, developed in Philadelphia, Pennsylvania from rural Pennsylvania and Maryland HHAs, to adjust owners' compensation for an HHA located in Wilmington, North Carolina. See Comprehensive Home Health Care I, Inc. v. Sullivan et. al., No. 99-9-CIV-7 (E.D.N.C. 1990). Similarly, Blue Cross and Blue Shield of Mississippi utilized the Tennessee Point System based on a computer listing of unidentified HHAs in rural Tennessee to adjust the salary of an HHA administrator working in Mississippi. Alexander's Home Health Agency, PRRB Hearing Dec. No. 88-D30 (September 2, 1988). There is no evidence, however, that what constitutes reasonable owners'/executives' salary in one region (e.g., in Philadelphia) also constitutes equally reasonable salary in another region (e.g., Wilmington, North Carolina). In addition, problems arise out of the methodologies listed above which use some system for awarding "points" (typically on a scale of 1 to 10) to an administrator based on a variety of factors allegedly relevant to determining an appropriate salary (e.g., years of experience, education, size of agency). Under these point system methodologies, "reasonable" salary is based solely on the total number of points awarded to the particular HHA owner/administrator. These systems are faulty, however, for a number of reasons.

First, there is no statistical support for the link between certain factors measured by the point systems and appropriate salary. Second, there is no evidence that the total number of points awarded under such systems fairly reflects the level of responsibility of an HHA owner/administrator (which should form the basis for determining appropriate salary). Third, different point systems use different factors for determining allowable salaries without evidencing the appropriateness of applying different factors to HHAs located in different regions or even within the same region. Finally, the point systems typically derive one fixed salary for all HHA owner/administrators who receive the same number of points, rather than indicating an appropriate salary range for the position. A range is clearly more appropriate because it allows more effective administrators to receive a reasonably higher salary than ineffective administrators with the same number of objectively-measured points.

Respondents argued below that the Secretary has acted pursuant to the owners' compensation regulation by allowing the Intermediary to develop "other appropriate means" for determining reasonable executive salaries All such "means," however, have consisted of post-hoc rationalizations. While the Secretary's interpretation of federal regulations is to be given great weight, the interpretation must be reasonable in light of the language of the regulation and the policy meant to be implemented. McCuin v. Secretary, 817 F.2d 161, 168 (1st Cir. 1987). If the Secretary's procedures under a regulation are not reasonable, the courts may invoke mandamus or federal question jurisdiction to hear a complainant's challenges - even though the court could not accept jurisdiction over a challenge to an amount determination brought by the same provider. McCuin, 817 F.2d at 166.

IV. By Prohibiting Jurisdiction In This Case, The Court Will Create Far-Reaching Implications For All Regulated Parties And Administrative Agencies In The United States

If the Respondents are protected from scrutiny in this case for failing to follow Medicare regulations and general instructions

pertaining to owners' compensation, a dangerous precedent will be set for Medicare and all other administrative agencies.

First, there will be nothing to stop the Respondents in this case from refusing to follow other regulations and general instructions relating to other Medicare matters. A decision to deny the courts' jurisdiction over issues outside the purview of the Medicare administrative system clearly allows the Secretary and Intermediary to operate without check on all Medicare matters which do not involve claims for reimbursement subject to PRRB review.

Second, because they will have no opportunity for redress through either the administrative or judicial system, providers (including hospitals and nursing homes, etc.) will face no choice but either to accept arbitrary actions by the government or stop participating in the Medicare Program altogether. Thousands of PRRB appeals on cost report disputes are already filed each year through the Medicare Program which challenge the amount of reimbursement paid in particular cases, and a backlog is resulting. In fact, the PRRB is currently scheduling hearings for 1995 on reimbursement claims arising from cost reporting years ending prior to 1992. It is unlikely that many providers will continue to participate in the Medicare Program if both the rules and amounts are always at issue.

Finally, a decision by this Court to refuse jurisdiction in the present case would substantially reduce the accountability of all regulatory agencies. The jurisdictional issues raised in this case affects all regulated parties - not just Medicare providers - and involves fundamental questions of constitutional and administrative law and the right of all regulated parties in this country to enforce the law against the government.

V. Respondents' Arguments That §405(h) Precludes Jurisdiction In This Case Are In Error

As stated above, The Fourth Circuit held that §405(h) precludes jurisdiction in this case. Total Care, Inc. v. Sullivan, No. 91-1514 (4th Cir. 1991). Other circuits, however, would clearly have accepted jurisdiction in this case because Total Care's complaint does not

involve a "claim" for reimbursement under the Medicare Act, and its complaint is not subject to review by the PRRB. There is therefore a split in the circuits on the issues raised herein, and this case is suitable for review by this Court. In addition, nothing can be gained by postponing judicial review any further as the Secretary has already failed to act in over twenty years.

A. The Circuit Courts Of Appeals Are Divided On The Issue Of Jurisdiction In Light Of §405(h) Because Of The Important Constitutional Questions Raised

Recent cases in circuits other than the Fourth Circuit hold that §405(h) does not preclude judicial review in Medicare cases that raise issues outside the scope of administrative review. These cases state that federal question and/or mandamus jurisdiction are available for causes of action which are otherwise unreviewable despite §405(h).

In their reply brief filed with this Court, Respondents rely primarily on this Court's decision in Heckler v. Ringer, 466 U.S. 602 (1984), for their argument that §405(h) precludes the courts from exercising federal question jurisdiction in this case (Brief for Federal Respondents in Opposition ("Resp.") at pp. 9-11). During the years since Ringer was decided in 1984, however, various courts have also addressed the jurisdictional issue. While the Fourth Circuit concluded that §405(h) bars jurisdiction even where no other avenue for relief is available, other courts have decided that jurisdiction in such cases is not precluded.

For example, in Beverly Hospital v. Bowen, No. 88-5011 (D.C. Cir. 1988), several hospitals successfully challenged a Medicare regulation which required them to provide photocopies of medical records to peer review organizations at their own expense. The Secretary tried to argue that 42 U.S.C. §1395oo, which requires presentation of claims to the PRRB, was the exclusive avenue for relief for the providers. The United States Court of Appeals for the District of Columbia Circuit, however, held that:

The 42 U.S.C. §1395oo route is indeed exclusive when it is genuinely

available to provide redress; when that is not the case, however, parties may invoke general federal question jurisdiction, 28 U.S.C. §1331 (1982), as was done in this case and in Burlington Memorial Hospital [644 F.Supp. 1020 (W.D. Wis. 1986)]. See National Ass'n of Home Health Agencies v. Schweiker, 690 F.2d 932, 936-41 (D.C. Cir. 1982), cert. denied, 459 U.S. 1205 (1983); College of Am. Pathologists v. Heckler, 734 F.2d 859, 862-63 (D.C. Cir. 1984). Beverly Hospital, as reprinted in Medicare and Medicaid Guide (CCH) ¶37,814 at p. 19789; see also American Hospital Association v. Sullivan et. al., No. 88-2027 (D.D.C. 1990). The court went on to criticize the Secretary for wanting to send the providers back to the Intermediary and PRRB with no valid regulations to apply. The court stated that "[b]ureaucratic ordering of this sort should not go unchecked by a reviewing court." Id. at pp. 19789-19790.

Similarly, the Secretary in the present case would send Total Care back to continually re-present its claims against the lack of salary guidelines to the Intermediary and PRRB without developing any valid methodology for them to apply. For over twenty years the government has failed to enforce the applicable Medicare regulations and general instructions which require the development of a rational system for making salary adjustments. As the PRRB lacks any power to order the Secretary to enforce his own rules on this matter, Total Care's present claims could not be addressed by another attempt at such a futile process.

As one circuit court recently stated:

[T]he Secretary cannot relegate providers to a dead-end procedure under the Medicare statute, and then argue that the provider loses because the Medicare statute is the exclusive means of redress. When such bureaucratic red tape strangles a provider's right to judicial review, the court may invoke its federal question jurisdiction. Memorial Hospital v. Sullivan, No. 91-727 (D.C.Cir. 1991) as reprinted in CCH ¶39,723 at pp. 28,718-28,719.

In American Hospital Association v. Sullivan, several hospital associations challenged a Medicare regulation, which prohibited providers from billing liability insurers, as being in violation of the "secondary payor" provisions of the Medicare Act. The Secretary

sought to dismiss the case for lack of jurisdiction under 42 U.S.C. §1395oo. The district court stated that:

Courts have recognized that when a particular case is not cognizable under any of the administrative schemes set up in the Medicare statute, then a District Court does have jurisdiction to hear the matter. American Hospital Association, as reported in CCH ¶38,537 at p. 23,017-6.

For cases where courts have accepted mandamus jurisdiction despite §405(h) on similar grounds, see Samaritan Health Center v. Heckler, 636 F.Supp. 503 (D.D.C. 1985); Hennings v. Heckler, 601 F. Supp. 919 (N.D. Ill. 1985), citing City of New York v. Heckler, 742 F.2d 729 (2d Cir. 1984), aff'd, Bowen v. New York, 476 U.S. 467 (1986), Dietsch v. Schweiker, 700 F.2d 865 (2d Cir. 1983), Lopez v. Heckler, 725 F.2d 1489 (9th Cir. 1984) vacated and remanded on other grounds, 469 U.S. 1082 (1984), Mental Health Association of Minnesota v. Heckler, 720 F.2d 965 (8th Cir. 1983), Belles v. Schweiker, 720 F.2d 509 (8th Cir. 1983), Ellis v. Blum, 643 F.2d 68 (2d Cir. 1981), Bellantoni v. Schweiker, 566 F.Supp. 313 (E.D.N.Y. 1983), Dixon v. Quern, 537 F.Supp. 990 (N.D.Ill. 1982), Silvis v. Heckler, 578 F.Supp. 1401 (W.D.Pa. 1984), Sinatra v. Heckler, 566 F.Supp. 1354 (E.D.N.Y. 1983).

B. Nothing Can Be Gained By Dismissing This Case Back To The Administrative System

Contrary to Respondents' assertions, judicial review over this case would not "prematurely interfere" with the administrative agency process or prevent the agency from "applying its expertise" (see Resp. at p. 11). The agency is currently taking no action on the issue of owners' compensation and has not taken any such action since 1974.

In addition, dismissing this case in favor of administrative remedies would clearly not "obviate the need for judicial review," as Respondents argue (see Resp. at p. 11). The reason is simply that the administrative process lacks authority to address the provider's claims.

Moreover, federal regulations require the Intermediary to determine reasonable executive compensation based on "comparable" salaries

paid in comparable facilities or "other appropriate means." As the Secretary has not enforced his instructions under this regulation in over twenty years, it is unlikely that, absent judicial intervention, we can expect him voluntarily to do so in the near future.

C. Total Care's Complaint Does Not Involve A "Claim" Under The Medicare Act Subject To Redress Through The Administrative Procedure

Section 405(h), by its terms, involves only a "claim" arising under the Medicare Act. Several courts have held that challenges to methodology - rather than amount - are not "claims" subject to the restrictions of this section.

Recently, in Americare Home Health Agency v. Sullivan, et. al., No. 90-2950-HB (D.Tenn. 1992), Blue Cross and Blue Shield of South Carolina (one of the same Respondents in the present case before this Court) attempted to recoup certain overpayments made to an HHA by means of offset without complying with applicable Medicare regulations. In response to a suit filed by the HHA, the defendants argued that the claim was barred by §405(h). The court held, however, that the HHA's complaint was not a "claim" arising under the Medicare Act, but dealt with the defendants' method of recouping alleged overpayments in violation of federal regulations.

The court quoted extensively from an earlier decision in Elk Valley Professional Affiliates, Inc. v. Sullivan, No. 4-90-198 (E.D. Tenn. 1991), where the magistrate stated:

This is not a case where the claims are, "at bottom," claims about how much the Medicare program should pay plaintiff for services performed. [] Plaintiff concedes that "how much" claims are subject to the administrative process. The plaintiff does not seek increased Medicare reimbursement; rather, the plaintiff seeks to compel the defendant [Secretary] to follow the federal regulations regarding the appropriate method of recouping an alleged overpayment. If the defendant is right that there is an . . . overpayment, the defendant will recover all of that money, with interest, regardless of what takes place

in this lawsuit. This case will in no way affect the administrative appeals process.

Where, as here, a plaintiff's claims are not within the statutory jurisdiction of the administrative review entity, jurisdiction can be based upon 28 U.S.C. §1331[]. I find that the court has subject matter jurisdiction... Id. at pp. 29,607-29,608 (emphasis in original).

Similarly, as Total Care has repeatedly stated, this lawsuit is not a "how much" claim for increased reimbursement for executive compensation. Contrary to Respondents' arguments, that Total Care prevailed at the PRRB is not determinative because this lawsuit seeks to enforce the stated methods for making executive compensation adjustments under federal regulations. Moreover, there is no guarantee that Total Care would receive increased reimbursement under the system it seeks to enforce. As no valid surveys of "comparable" providers have ever been performed and as no rules explain "other appropriate means," there is no way of telling how Total Care's owners' salary compares to other providers.

Finally, this case does not hamper the administrative appeals process which has proceeded on its own course while this case has progressed through the courts. This case simply seeks to enforce the federal regulatory system for determining reasonable owners' compensation so that providers, the Intermediary, and the PRRB have valid rules to apply.

VI. Conclusion

For all of the foregoing reasons, the Petitioner respectfully requests that this Court issue a writ of certiorari in this case.

Respectfully submitted,

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